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ABSTRACT

Excerpts are presented from the March 1983 hearings on oversight and reauthorization of the Rehabilitation Act of 1973. Prepared statements are included from federal officials; representatives of professional rehabilitation and education associations and state and local agencies; students; and other interested persons. In addition to the statements, letters and supplemental materials on the topic are also provided from associations, agencies, university faculty, and federal officials. The statements touch on amendments to the act, provisions for independent living, rehabilitation research, and rehabilitation training. (CL)

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OVERSIGHT AND REAUTHORIZATION HEARING ON THE REHABILITATION ACT OF 1983

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

HEARINGS HELD IN WASHINGTON, D.C. ON MARCH 21 AND 23, 1983

Printed for the use of the Committee on Education and Labor

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OVERSIGHT AND REAUTHORIZATION HEARING ON THE REHABILITATION ACT OF 1983

MONDAY, MARCH 21, 1983

House of Representatives,
Committee on Education and Labor,
Subcommittee on Select Education,
Washington, D.C.

The subcommittee met, pursuant to call, at 10 a.m., in room 2261, Rayburn House Office Building, Hon. Austin J. Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Williams, and Bartlett.

Staff present: Judith Wagner, professional staff; Tanya Rahall, staff assistant; and Patricia Morrissey, minority legislative associate.

Mr. **Murphy**. Good morning.

This morning's hearing is the first of 2 days of oversight in preparation for the reauthorization of the Rehabilitation Act. We are fortunate in this subcommittee to have jurisdiction over several programs that have always received strong bipartisan support in Congress. The Rehabilitation Act is one of them.

Even during the year of Gramm-Latta, when the administration was calling for block grants for almost every social program, including the Rehabilitation Act, and while Congress was giving the President much of what he wanted, not a voice was heard from either side of the aisle in either the House or the Senate in support of making changes in the Rehabilitation Act.

When the dust had finally settled in fiscal year 1981, Congress had seen fit to extend the act and again increase its funding, although modestly. When you have a winner, a program that works, it only makes sense to stick with it. You don't abandon it. When possible, you strengthen it.

For this reason I believe it is safe to say that the administration will not find much support in Congress for its latest recommendation for abandoning the Rehabilitation Act, the New Federalism block grants.

We have not yet received the additional proposal the administration says it will be sending us to amend the Rehabilitation Act, and I am not sure why we need two bills since we already know what they really want to do to the program.

Again, the administration should recognize that Congress will not make changes in this act that might jeopardize its remarkable record of success.

Last week a number of my colleagues and I introduced a rehabilitation bill that I believe Congress will support. In recognition of the long history of success of the State grants portion of the act, the bill would make the State grants entitlement a permanent authority. It would also authorize increases in the State grants which would, over the next 4 years, restore the spending power that has been lost since 1979 due to inflation.

Since 1979, the drop in the number of both severely and nonseverely disabled cases shows a clear decline in the ability of the States to serve eligible clients. At the very least our objective should be to get back to the point where the decline began.

We want to hear this morning from rehabilitation practitioners and from those who are on the receiving end of the programs authorized by the act. We will welcome your comments on the bill we have introduced, on the administration's proposals, and any recommendations you may have on how we might strengthen and improve the act. We appreciate your presence here today.

Mr. Steve Bartlett of Texas.

Mr. BARTLETT. Thank you, Mr. Chairman.

As a new member of this subcommittee, and as the ranking minority member of this subcommittee, I take special pleasure in joining with you and our other colleagues in beginning work on hearings and the markup this week of the reauthorization of the Rehabilitation Act of 1973.

I will keep several important points in mind as we go about reauthorizing and examining the Rehabilitation Act.

First, we have to remember that any State or Federal program which helps Americans to obtain and retain private long-term meaningful employment is significant. Because vocational rehabilitation goes a long way toward providing this kind of employment future for the disabled. we must identify and expand the cost effectiveness of the vocational rehabilitation program.

Second, the need is great. At this committee level we must determine how many persons can be helped by encouraging use of the much larger resources available in the private sector. The burden of preparing handicapped persons for employment must be shared by the public and private sector with Federal dollars being used for leverage and as a catalyst.

Third, State vocational rehabilitation agencies are faced with the same economic realities that we are faced with here at the Federal level; that is, steadily declining purchasing power.

I do not believe that the solution to reversing the trend of decreasing purchasing power lies solely in increased appropriations. Instead, we must explore new ways to use the Federal resources that we now have as leverage to increase private sector funding.

Fourth, the handicapped are especially hard hit by unemployment, yet the handicapped share with all other Americans a stake in the best and the most effective solution to unemployment; that is, a healthy economy with low interest rates and low inflation and a private sector that is vigorous enough to provide all Americans, including the handicapped, with meaningful jobs. To achieve this goal we must make a cooperative effort to control the growth of the total size of Federal spending.

Fifth, one of the issues that this reauthorization will focus on is the appropriateness of increased Federal dollars for the Rehabilitation Act. There is a consensus on the need to help handicapped Americans enter the work force. That should be the focus of this act. However, we do need to look at all the methods that may be available for achieving that end. The key is in leveraging existing dollars, not necessarily in increasing those dollars.

Sixth, another issue that we will hear in this reauthorization is the need to remove the drain on other Federal programs, such as social security, that benefits to the handicapped represent. Reducing that drain in social security dollars will be accomplished by training handicapped persons and placing them into private sector jobs.

Last, I believe that we should examine the terms of the existing formula to find a way to encourage and to reward programs that are successful in placing people in permanent employment.

I look forward to this week's hearings on the Rehabilitation Act reauthorization. I hope that this committee can produce a bill that is in the best interest of all handicapped persons, so their talents and abilities can be maximized and they can live independent, meaningful lives.

Thank you, Mr. Chairman.

Mr. MURPHY. Thank you, Mr. Bartlett.

The first witnesses we have this morning are a panel consisting of Mr. Marvin Spears, president of the National Rehabilitation Association in St. Paul, Minn.; Mr. Jim DeJong, Access Living, Chicago, Ill.; and Mr. Lex Frieden, director of the Independent Living Research Utilization Project, Houston, Tex.

Will the three of you gentlemen arrange yourselves at the witness table, and we will proceed in that order.

Mr. Spears, you may proceed first.

STATEMENT OF MARVIN O. SPEARS, PRESIDENT, NATIONAL REHABILITATION ASSOCIATION, ST. PAUL, MINN.

Mr. SPEARS. Thank you, Mr. Chairman.

My name is Marvin Spears. As president of the National Rehabilitation Association I very much appreciate the opportunity to present the views of NRA and its seven divisions.

The many years of hard work and dedication you and members of the subcommittee have committed to increasing opportunities and options to persons with disabilities is well known to our organization and deeply appreciated.

NRA, founded in 1925, has an active membership of 20,000. Our association's mission and purpose is founded on advocacy, advocacy for options and opportunities for our Nation's persons with disabilities.

Today, Mr. Chairman, I would like to present the recommendations of NRA relative to the Rehabilitation Act of 1973 as amended. These recommendations will relate both to the act in its entirety, and to specific sections.

First, Mr. Chairman, I would suggest that we feel strongly that the act is a hallmark of intelligent, comprehensive and thoughtful efforts to encompass public policy and national legislation. All phases of the act have worked effectively. We have urged that you maintain the integrity of the programs and rights contained in the act.

The foundation of the programs authorized under the Rehabilitation Act is the basic State vocational rehabilitation program. This program is provided to persons with disabilities through a unique Federal-State partnership that has functioned successfully for over 60 years. It is a proven, finely tuned program that has stood the test of time, has been well managed and proven to be highly cost effective.

The Rehabilitation Services Administration's latest report to Congress estimates that the benefit-cost ratio exceeds 10 to 1. In my own State of Minnesota, we have determined that the return on a public investment in a basic State vocational rehab program is 34.8 percent. This is a very impressive return on any investment.

Of equal importance are the benefits of this program to the persons with disabilities. Behind the cost benefit studies are individuals who have been provided opportunities to earn money and gain the self-esteem that comes from a paycheck.

To be working is to be part of mainstream America. This program helps persons with disabilities work and enter that mainstream.

However significant the benefits of the program are, funds have not been made available at a level necessary to maintain the services needed by persons with disabilities. Since this program pays significant dividends on public investment, we urge that you increase that public investment significantly.

Next I would like to discuss the program of services authorized under title VII, Comprehensive Services for Independent Living. This program has been partially implemented by the provision of funds to establish and support Centers for Independent Living.

There are now 135 such centers providing services to people with disabilities all over our Nation. Some State rehabilitation agencies have opted to operate these programs directly; many more have contracted with private, nonprofit, community-based, consumer-directed organizations to provide the services.

I wish very much, Mr. Chairman, that I could present to you significant nationwide statistics relative to this program. However, this administration has not seen fit to institute a meaningful, nationwide reporting system, nor apparently do they have plans to do so this year. I believe that you, as the Nation's policymakers, are entitled to this information.

Independent living services not only enable persons with severe disabilities to live independently, but they reduce the public costs associated with disability. Thirteen centers in Federal region V collaborated to accumulate a series of documented individual histories showing clearly that the provision of independent living services is not only of benefit to the individuals involved, but a cost savings as well.

Of the 18 individuals portrayed in this report, 10 are likely to become employed. Net savings in public expenditures to these individuals for various kinds of public assistance, including social security benefits, has been reduced by $135,000 per year. This limited evidence shows clearly that independent living services provide not only personal benefit to the individuals served, but a cost savings as well.

Currently, only part B has received funding and, as valuable as the Centers for Independent Living are, it is essential the program be fully implemented, as was intended in the amendments of 1978. NRA urges that Congress now fund part A and maintain the existing level of funding for part B.

Next, Mr. Chairman, I would like to address the rehabilitation research needs as reflected in the funding request for research directed through the National Institute of Handicapped Research.

This institution is charged with increasing the knowledge which will help us meet the challenges in serving individuals with disabilities. NIHR is also charged with disseminating information in order that persons with disabilities may benefit from research findings quickly.

I would like to point out that we are entering a new era in this country. Science and technology are increasingly brought to bear on all aspects of our life. Increased funding for research activities is vital if research findings are to be brought to bear on the problems faced by our Nation's citizens with disabilities. Increases in research funding will pay direct dividends in the future.

Next I would like to address the need for training individuals working to increase opportunities and options for persons with disabilities.

Significant numbers of qualified rehabilitation professionals are essential for assuring the availability of a broad range of services needed to enable persons with disabilities to enter the work force and to live and function independently.

The quality and scope of any program is directly related to the quality of the persons providing services. NRA supports an increase in funding for rehabilitation training activities.

Finally, Mr. Chairman, I would like to emphasize that although time does not permit a full discussion of the other programs authorized under the act, note should be taken that the special discretionary grant categories are of importance to the overall scope of the services in the act.

Of special mention are projects with industries which have demonstrated that close ties with the business community can enable persons with disabilities to become employed by a variety of innovative, hands-on techniques. NRA supports increased funding for these projects, as well as others in the special discretionary grant category.

Mr. Chairman, in conclusion I would like once again to thank you very much for the opportunity of presenting our views on this very important matter.

Mr. MURPHY. Thank you, Mr. Spears.

[The prepared statement of Marvin Spears follows:]

PREPARED STATEMENT OF MARVIN O. SPEARS, PRESIDENT, NATIONAL REHABILITATION ASSOCIATION

Mr. Chairman, members of the Sub-Committee, my name is Marvin Spears. As President of the National Rehabilitation Association, I very much appreciate this opportunity to represent the views of NRA and its seven divisions — the National Rehabilitation Counseling Association, the Job Placement Division, the National Association for Independent Living, the National Association of Rehabilitation Instructors, the National Association of Rehabilitation Secretaries, the National Rehabilitation Administration Association and the Vocational Evaluation and Work Adjustment Association.

The many years of hard work and dedication you and members of the Sub-Committee have committed to increasing opportunities and options for persons with disabilities is well known to our organization and deeply appreciated.

For nearly 60 years, our organization has worked with you to ensure that persons with disabilities obtain the rights to which they are entitled and the special services that they need to become independent, productive members of society.

NRA, founded in 1925, has an active membership of 20,000 individuals, including professional workers in all phases of rehabilitation, persons with disabilities, and other individuals who share our commitment. Our Association's mission and purpose is founded on advocacy -- advocacy for options and opportunities for our Nation's persons with disabilities to work, live lives of their choosing, and contribute to our society.

Today Mr. Chairman, members of the Sub-Committee, I would like to present the recommendations of NRA relative to the Rehabilitation Act of 1973, as amended. These recommendations will relate both to the Act in its entirety and to specific sections.

THE REHABILITATION ACT, AS AMENDED

First, Mr. Chairman, let me offer our Association's recommendations on the Rehabilitation Act, as amended in its entirety. We believe strongly that the Act, as amended, is a hallmark of intelligent, comprehensive and thoughtful efforts at encompassing public policy in national legislation. All phases of the programs and rights authorized in the Act have worked effectively. We urge that you maintain the integrity of the programs and rights contained in the Act and reject efforts to significantly alter the basic dimensions of our Nation's rehabilitation programs. We believe it would be folly to change the finely tuned elements contained in this Act for purposes of satisfying the abstract needs of some ideology.

BASIC STATE VOCATIONAL REHABILITATION SERVICES PROGRAM
SECTION 100 (B) (1)

The foundation of the programs authorized under the Rehabilitation Act is the basic state Vocational Rehabilitation services program which ensures that a wide range of rehabilitation services are available to persons with all types of disabilities. This service program is provided through a unique federal/state partnership that has functioned very successfully for over 60 years. It is a proven, finely tuned program that has stood the test of time and has been well managed and highly cost effective. Indeed, the Rehabilitation Services Administration's latest report to Congress estimates that the benefits/cost ratio exceed $10 to 1. Estimates obtained from other than federal sources are even higher.

For instance, Mr. Chairman, in my own state of Minnesota, we have determined that the return on the public investment in the basic state Vocational Rehabilitation program is 34.8 percent. That is a very impressive return on any investment!

The taxpayers of our community are well rewarded for their investment of dollars in the rehabilitation program.

Of equal importance are the benefits of this program to persons with disabilities. Behind the cost/benefit studies are individuals who have been provided opportunities to earn money and gain the self-esteem that comes from a paycheck. The economic gains for individuals with disabilities leads to personal gains of a less tangible but equally significant order. Economic independence gives persons with disabilities options for living that are available no other way. According to the National Jaycee Creed, "Work gives meaning and purpose to life". To be working is to be part of mainstream America. This program helps persons with disabilities work and enter that mainstream.

All of us in America benefit from the rehabilitation program. Our Nation's economy improves as we more effectively utilize the productive capacities of persons with disabilities. Employers are provided a ready source of trained, willing workers. The rehabilitation program acts as a magnet drawing funds and commitments from our communities designed to enhance the options and opportunities for their community members with disabilities. In summary, Mr. Chairman, members of the Committee, the benefits of the state/federal rehabilitation program are very significant and touch the lives of virtually every citizen in the country.

However significant the benefits of this program are, funds have not been made available in sufficient amounts to maintain the level of services and opportunities provided to persons with disabilities.

In recent years, Congress has placed an emphasis on first serving the severely disabled, a mandate which NRA wholeheartedly endorses and which rehabilitation agencies have sought diligently to carry out. Unfortunately, this laudable goal has not been reinforced by a level of funding necessary to maintain the level of service this program deserves. Fewer individuals are now being rehabilitated under the state/federal rehabilitation program though there has been an increase in the proportion of severely disabled persons served. Although appropriations are not within the scope of this sub-committee, Congress should be made aware that it is estimated to be two to two and one-half times more costly to provide rehabilitation services to those individuals with severe disabilities. Federal funds must increase to properly implement this important and significant mandate.

The basic state rehabilitation program has worked and is working effectively to ensure that persons with disabilities can become personally and economically independent. It is a program proven effective through many years and returns to society's significant benefits.

We urge the sub-committee to authorize sufficient funds to enable the program to better meet the economic and job needs of persons with disabilities.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING - TITLE VII

Next, I would like to discuss the program of services authorized under Title VII, Comprehensive Services for Independent Living. Independent Living services, authorized in the amendments to the Rehabilitation Act in 1978, have been implemented by the provision of funds to establish and support Centers for Independent Living. One hundred thirty five (135) of these Centers have been established and are now helping persons with severe disabilities live and function more independently in their homes, families and communities. Some state rehabilitation agencies have opted to operate these Centers directly, but many have contracted with private non-profit community-based organizations to provide the services.

I sincerely wish, Mr. Chairman and members of the Sub-Committee, that I could present to you significant nationwide information relative to the implementation of this vital program. However, the Administration has not seen fit to institute a meaningful nationwide reporting system, nor apparently do they have plans to do so this year as Comprehensive Services for Independent Living is not a work plan priority within the current Administration.

I believe that you, as the Nation's policy-makers, are entitled to this information, as well as we in advocacy organizations.

Independent Living services have great significance to persons with severe disabilities. All of us have needs which we meet routinely for housing, transportation, personal help, access to our community's resources. Persons with severe disabilities have these needs too and the fulfillment of these needs and desires is what Independent Living services is all about. Independent Living services provide options for persons with disabilities so that they can manage their lives themselves. When persons with severe disabilities have a predictable source of income, hopefully, through employment, when they have accessible and affordable housing, when they have accessible and adequate transportation and when they have the support of friends and associates, they can and, in fact, do live and function independently and provide a significant enrichment to the communities in which they reside. When these basic conditions necessary for individuals with severe disabilities to live independently are met, a significant portion of them can avail themselves of services offered through the basic state rehabilitation program and become economically independent through work.

These services, Mr. Chairman, members of the Sub-Committee, not only enable persons with severe disabilities to live independently, but they reduce the public costs associated with disability. The experience of the Centers for Independent Living even though they have been operational only a few years, has provided dramatic evidence that given Independent Living services, persons with disabilities require smaller expenditures of state, federal and local support dollars in addition to improving their ability to function in the employment market or in preparation for employment.

For instance, in Federal Region V, which encompasses the states of Minnesota, Wisconsin, Illinois, Michigan, Indiana and Ohio, 13 Centers for Independent Living collaborating voluntarily with the Chicago Regional Office of the Rehabilitation Services Administration, accumulated a series of documented individual histories showing clearly that the provision of Independent Living services are not only a benefit to society in providing opportunities and options, but cost effective as well.

Ten of 18 individuals portrayed in this report will likely become (or are currently) employed.

Net savings in public expenditures to these individuals for various kinds of public assistance has been reduced by $135,750 per year.

This limited evidence shows clearly that Independent Living services produce not only personal benefit to the individuals served, but cost savings to society as well.

Currently, Mr. Chairman and members of the Committee, only Part B of the Act has received funding. As valuable and significant as the services provided by the Centers for Independent Living are, it is essential that the program be fully implemented as was intended in the Amendments of 1978.

NRA urges that Congress now fund Part A of Title VII. Funds for Part A, administered by the state rehabilitation agency, would enable this important program to more fully reach the mandate envisioned in the Amendments. Cooperatively with the Centers for Independent Living, services made available under Part A would enhance, expand and stabilize the Independent Living program.

NRA urges, additionally, a funding level adequate to support the existing Centers.

REHABILITATION RESEARCH

Next, Mr. Chairman and members of the Committee, I would like to address the rehabilitation research needs as reflected in the funding requests for federal research directed through the National Institute of Handicapped Research, Section 201, (A) (1). This institution is charged with coordinating efforts to increase the knowledge which will help us overcome the challenges associated with providing rehabilitation services to those individuals with severe disabilities. Through rehabilitation research and training centers, methodology and delivery systems are improved while rehabilitation engineering centers seek to apply new and innovative methods to overcome identified problems in the area of rehabilitation. NIHR is also charged with the dissemination of such information in order that persons with disabilities may benefit from the research findings as quickly as possible. Together, these research activities provide a focused coordinated effort to expand our ability to serve persons with severe disabilities and to improve the overall effectiveness and success of the program.

Mr. Chairman, members of the Committee, I would like to point out that we in this Nation are entering a new era. That era has been described as the era of high technology. Basic science and technology are being increasingly brought to bear on all aspects of life. Increased funding for research activities are vital if the significant increase in research findings and research capabilities are to be brought to bear on the problems faced by our Nation's citizens with disabilities. Indeed, much progress has been made to date with the limited funds available. It is the view of NIHR that increases in funding research activities will pay direct dividends in future years as the general field of science advances and as our directed research enables us to utilize research findings to minimize the impact of a disabling condition on the lives of persons and to find increasingly effective ways to improve the opportunities and options for persons with disabilities.

There are new scientific horizons that should be explored and new technological advances in the areas of robotics, limb regeneration and bio-genetics, and engineering could cause us to re-define our concept of disability.

REHABILITATION TRAINING

Next, Mr. Chairman and members of the Committee, I would like to address the needs for training individuals working to increase opportunities and options for persons with disabilities. Sufficient numbers of qualified rehabilitation professionals are absolutely essential for providing a broad range of services needed to enable persons with disabilities to enter the work force and to live and function more independently. In recognition of this fact, federal funds have been made available for rehabilitation training for over 30 years. Currently, the rehabilitation training program encompasses grants to states and public or non-profit institutions or agencies, including universities, to support both long and short-term training over the broad spectrum of rehabilitation specialties. Programs of continuing education designed to maintain and update high standards of services are also authorized which help rehabilitation service providers respond to changing priorities and needs within the scope of rehabilitation programs.

The quality and success of any program is directly related to the quality of the service providers charged with turning rehabilitation goals into realities. It is, therefore, disturbing to note that major shortages have been documented in many rehabilitation professions. If allowed to continue, the rehabilitation program will necessarily provide a lower standard of service, consequently, weakening the overall effectiveness and success of a heretofore exemplary program. That cannot be allowed to happen.

Finally, Mr. Chairman and members of the Committee, I would like to emphasize that although time does not permit a full discussion of the other programs authorized under the Act, note should be taken that the special discretionary grant categories are of great importance to the overall comprehensive scope of the services authorized under the Rehabilitation Act. These programs fill very special and specific needs and provide unique opportunities for increasing the effectiveness of the program.

Of special mention are Projects With Industries, a program which has demonstrated that close ties with the business community can enable persons with disabilities to become employed in the business sector by use of a variety of innovative hands-on techniques. NRA supports increased funding for these projects.

Mr. Chairman and members of the Committee, in conclusion, NRA would like to once again thank yo for the opportunity of presenting our views on the Rehabilitation Act of 1973, as amended.

I would summarize our recommendations as follows:

I. The Rehabilitation Act of 1973, as Amended. We urge that the Act be retained - in total - without substantial changes.

II. Basic Vocational Rehabilitation Services Program. We urge increased funding to more adequately meet documented needs.

III. Comprehensive Services for Independent Living. We urge funding for Title VII, Part A and Continuation funding for Part B.

IV. Rehabilitation Research. We urge increased funding.

V. Rehabilitation Training. We urge increased funding.

VI. Special Discretionary Projects. We urge increased funding.

The Rehabilitation Act and its programs have proven to be a marvelous mechanism for meeting the needs of persons with disabilities and giving significant benefits to society as well.

APPENDICES

I. Executive Summary of [illegible] ECONOMIC ANALYSIS -- A Modified Cost/Benefit Procedure

II. Independent Living Centers in Region V -- THE ECONOMIC AND SOCIETAL BENEFITS OF INDEPENDENT LIVING SERVICES

III. Promoting Rehabilitation Programs

Executive Summary
of
MINNESOTA DVR FY 1981 ECONOMIC ANALYSIS
A Modified Cost/Benefit Procedure

by

Han Chin Liu, Ph. D.

March 1982

Division of Vocational Rehabilitation

Minnesota Department of Economic Security

Executive Summary

This study analyzes the economic impact of vocational rehabilitation in Minnesota using a modified cost/benefit procedure developed by the Oregon Vocational Rehabilitation Division. The analysis was based on the fiscal year 1981 Client Service Report data compiled by the Minnesota Division of Vocational Rehabilitation (MDVR).

The costs of rehabilitation are the total costs of the vocational rehabilitation program for the fiscal year 1981 and the actual case service expenditures for the FY 1981 rehabilitants incurred in prior years. Costs excluding case service expenditures and some non-rehabilitation related costs are termed overhead costs. Overhead costs are allocated to all closed cases proportional to the length of time spent from application to closure.

The benefits of rehabilitation are client's earnings gain due to vocational rehabilitation. This earnings gain is the difference between client's referral earnings and earnings at closure. Client's earnings at referral were adjusted for changes in wage rate over the period of time from referral to closure before computing the difference. The difference was then reduced to reflect the effects of (1) uncertainty (by discounting), (2) future unemployment, (3) client mortality, (4) referral earnings underestimation, and (5) gain not attributable to vocational rehabilitation on future earnings. Fringe benefits are then added to the earnings to derive total clients benefits.

The benefits of vocational rehabilitation cover not only the rehabilitants because of their increased earnings resulting from vocational rehabilitation but also "the taxpayers" due to increased taxes paid by the rehabilitants and their decreased use of public assistance.

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The study shows that the average additional income earned by each rehabilitated person over his/her remaining working life will be $39,296.94, in 1981 dollars. The rehabilitated clients will increase their earnings by $11.44 for every vocational rehabilitation dollar spent.

The study also shows that tax dollars spent to help disabled persons get jobs are an outstanding investment of public money. In Minnesota, every tax dollar spent by the joint state-federal vocational rehabilitation program is returned to the state and federal government in 2.87 years. The annual rate of return for the investment on vocational rehabilitation program is 34.8 percent. The study estimates that Minnesota DVR will return $3.32 to "the taxpayers" for every vocational rehabilitation dollar it spent.

The cost/benefit model used in this study can report economic costs and benefits for all clients or for any subgroup of DVR clients. This study also reports key findings by client's status on various public assistance or insurance programs such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Workers' Compensation (W/C). Also reported in this study are the results of cost/benefit analyses of vocational rehabilitation by referral sources, administrative units of the agency, and client's characteristics including severity of disability, major disability group, and sex.

Executive Summary of Minnesota DVR FY 1981 Economic Analysis: A Modified Cost/Benefit Procedure

Introduction

The Minnesota Division of Vocational Rehabilitation adopted, with modifications, a conservative cost/benefit procedure developed by the Oregon Vocational Rehabilitation Division to analyze the economic impact of vocational rehabilitation[1]. The advantages of utilizing this procedure are:

(1) The procedure is a conservative cost/benefit model. It utilizes a series of adjustment factors to reduce gross earnings gain due to vocational rehabilitation. These factors include clients' possible unemployment in future, clients' mortality prior to retirement, underestimated clients' earning at referral, and earnings gain not attributable to vocational rehabilitation services.

(2) Costs in this model are computed on the individual client level, which enable program managers to analyze cost/benefit data for any grouping of disabled clients in order to increase program efficiency.

(3) The model is a computerized procedure which warrants data accuracy and manpower saving in the cost/benefit analysis. Because of its simplicity, program managers can conduct timely cost/benefit analyses to suit program needs.

The Costs of Rehabilitation

The costs of rehabilitation used in this model are the total costs of the vocational rehabilitation program for the fiscal year of interest, and the actual case service expenditures incurred in prior years for the rehabilitants of that year. Costs excluding cases service expenditures and some non-rehabilitation related costs are termed overhead costs. The overhead costs include expenditures for personnel and services related to the administration of the vocational rehabilitation program such as salary, rent, heat, lights, supplies, staff training, travel, contracts and grants.

This model allocates overhead costs to all closed cases (statuses 08, 26, 28, 30) proportional to the length of time they spent in the vocational rehabilitation process. Each individual client's share of overhead cost is computed. The vocational rehabilitation cost for an individual client is derived by adding his/her actual case expenditures to his/her share of overhead cost.

The average cost per rehabilitation is obtained by dividing the total costs for a given client group by its number of rehabilitants.

The Benefits of Rehabilitation

The benefits of rehabilitation designated by this model are client's earnings gain due to vocational rehabilitation. This earnings gain is the difference between client's referral earnings and earnings at closure. Clients' earnings at referral are adjusted for changes in wage rate over the period of time from referral to closure before computing the difference. The difference is then reduced to reflect the effects of the following factors on future earnings:

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1. uncertainty (by discounting),
2. future short--term unemployment,
3. client mortality prior to retirement
4. referral earnings underestimation, and
5. gain not attributable to vocational rehabilitation services.

Fringe benefits are then added to the earnings gains to derive total client benefits.

Assumptions

1. The discount rate of 10 percent is used to derive an annuity discount factor to estimate the present value of future earnings. Since vocational rehabilitation's funding sources are governments, the use of the interest rate on government bonds is deemed appropriate.
2. The unemployment rate is assumed to be 4.53 percent, which is the average of the unemployment rates in Minnesota for the last three years.
3. The mortality factur is assumed to be 3.5 percent, adopted from the Oregon model.
4. The underestimate of earnings capacity at referral is assumed to be 39 percent, adopted from the Oregon model.
5. Gain not attributed to vocational rehabilitation is assumed to be 20 percent, recommended by RSA[2].
6. Fringe benefits are assumed to be 20 percent of the total monetary earnings suggested by the agency's accounting unit, which is more conservative than the rate of 23.3 percent reported by the U.S. Department of Labor[3].
7. The tax rate is assumed to be 20 percent, recommended by the West Virginia Rehabilitation Research and Training Center[3].
8. Homemakers and upaid family workers are assumed to have zero earnings.
9. Gains obtained by 28 or 30 closures are not considered in the computation of program benefits.
10. All non-monetary benefits of vocational rehabilitation programs are not assessed by this model because of lack of data.

Glossary

1. The client's income cost/benefit ratio is the ratio of discounted average future income gain to the average cost of rehabilitation. It is obtained by dividing the average discounted expected earnings gain by the average cost per rehabilitaiton. For Minnesota DVR in FY 81, this ratio was 11.44, implying that clients increased their earnings by $11.44 for every vocational rehabilitation dollar spent.
2. The average total client benefit is the average expected earnings gain discounted over the remaining working lifetime of the rehabilitated persons. On the average, each Minnesota rehabilitant of FY 81 was expected to have an additional earnings of $38,296.94, resulting from vocational rehabilitation, in his/her remaining working lifetime.

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3. The taxpayer's payback benefit/cost ratio is the ratio of the discounted average increase in taxes paid and reduction in reduced public assistance benefits to the average cost per rehabilitation. The tax rate used to calculate tax receipts is 20 [3] percent of gross earnings for state and federal income taxes and social security withholding. For Minnesota DVR in FY 81, this ratio was 3.32, suggesting that Minnesota DVR returned $3.32 to "the taxpayers" for every vocational rehabilitation dollar it spent.
4. The taxpayer's net profit per rehabilitation is that amount of money over the costs of rehabilitation which will accrue to the public through increased tax receipts and reduced public assistance payments over the remaining working lifetime of those rehabilitated. The estimated net profit for Minnesota taxpayers due to vocational rehabilitation in FY 81 was $7,758.25.
5. The number of years required to repay cost is obtained by dividing the annual total cost of rehabilitation by the annual total taxpayer's benefit, which is the combination of the annual increase in taxes and the annual reduction in public assistance. The result of analysis indicates that it would take 2.87 year for Minnesota DVR to repay the total rehabilitation cost it spent in FY 81.
6. The annual rate of return is a percentage rate of return which is computed by taking 1 to be divided by the number of years required to repay cost. The annual rate of return for Minnesota DVR in FY 81 was 34.8 percent.

Footnote

1. F.C. Collignon et. al. Benefit/Cost Analysis of Vocational Rehabilitation Services Provided by the California Department of Rehabilitation (Berkeley, California: Berkeley Planning Associates, 1977), p. IV - 9.
2. Bureau of Labor Statistics, U.S. Department of Labor, Employee Compensation in the Private Nonfarm Economy, 1977 (April, 1980), Summary 80 - 5.
3. R.K. Majunder, et. al. Benefit/Cost Analyses in Vocational Rehabilitation: A Simplified Approach (Dunbar, West Virginia: West Virginia Rehabilitation Research and Training Center, 1978), p.5.

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Table 1: Minnesota DVR FY 83 Economic Analysis by Client's SSI Status

SSI Status	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
SSI Client	$4,277.89	4.88	$18,898.14	1.47	$1,999.06	6.47	16.5
Non-SSI Client	3,307.22	11.80	38,286.59	3.43	8,025.75	2.78	36.0
All Agency	3,348.07	11.44	38,295.90	3.32	7,758.25	2.87	34.8

[**] Supplemental Security Income (SSI) payment recipients.

Table 2: Minnesota DVR FY 83 Economic Analysis by Client's SSDI Status

SSDI Status	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
SSDI Client	$3,415.21	6.84	$23,343.05	2.30	$4,429.25	4.15	24.1
Non-SSDI Client	3,344.48	11.69	39,101.75	3.37	7,937.42	2.82	35.5
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

[*] Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of these future benefits.

[**] Social Security Disability Insurance (SSDI) payment recipients.

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Table 3: Minnesota DVR FY 81 Economic Analysis by Workers' Compensation Status

Workers' Comp. Status	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Workers' Comp. Client	$2,576.01	19.33	$49,803.06	5.03	$10,383.58	1.89	52.9
Non-Workers' Comp. Client	3,508.18	10.22	35,862.90	3.06	7,215.71	3.12	32.1
All Agency	3,346.43	11.44	38,281.79	3.32	7,767.13	2.87	34.8

**Figures for all agency differ slightly from those shown in other tables because 18 cases did no have information on their Workers' Compensation Status.

Table 4: Minnesota DVR FY 81 Economic Analysis by Referral Sources

Referral Source	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Education Institutions	$4,825.57	7.89	$38,059.34	1.60	$ 2,914.56	5.94	16.8
Hospital	2,623.58	14.59	38,274.03	3.44	6,389.28	2.77	36.1
Health Organization	3,195.96	10.51	33,585.46	4.24	10,346.48	2.25	44.4
Welfare	3,369.57	8.32	28,021.56	6.58	18,804.75	1.45	69.0
Public Organization	2,859.01	14.54	41,576.98	4.14	8,981.37	2.30	43.5
Private Organization	2,727.06	14.15	38,584.72	3.98	8,117.68	2.40	41.7
Individual	2,874.30	13.61	39,108.65	3.94	8,460.91	2.42	41.3
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

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Table 5: Minnesota DVR FY 81 Economic Analysis by Administrative Area

Admin. Area	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
East Metro	$3,519.45	12.05	$42,420.37	3.38	$ 8,372.11	2.82	35.5
West Metro	3,323.22	11.46	38,073.87	3.05	9,458.42	2.48	40.3
Central	3,230.14	13.71	44,269.36	3.44	7,869.23	2.77	36.1
Northwest	3,320.95	10.74	35,732.04	2.61	5,344.23	3.68	27.4
Northeast	3,460.13	11.79	40,794.17	4.06	10,590.82	2.35	42.6
Southwest	3,167.41	10.08	31,925.69	3.05	6,489.28	3.12	32.1
Southeast	3,336.23	9.60	32,209.83	2.35	4,502.65	4.25	24.7
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

Table 6: Minnesota DVR FY 81 Economic Analysis by Client's Severity of Disability

Severity Dis.	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Severely Disabled	$3,579.20	9.26	$33,154.81	2.94	$6,944.70	3.26	30.9
Non-Severely Disabled	3,069.18	14.50	44,501.54	3.85	8,739.08	2.48	40.3
All Agency	3,348.07	11.44	38,296.94	3.32	7,758.25	2.87	34.8

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of these future benefits.

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Table 7: Minnesota DVR FY 81 Economic Analysis by Disability Group

Disability Group	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Visual	$2,151.08	15.36	$32,808.32	3.54	$ 3,388.30	3.75	26.7
Hearing	3,060.09	9.80	30,069.98	3.09	6,217.81	3.68	27.3
Orthopedic	3,291.73	12.40	42,586.47	3.67	8,030.32	3.09	30.8
Amputation	3,316.19	10.97	36,381.61	3.77	9,183.08	2.93	29.5
Personality** Disorder	2,733.43	14.27	39,004.79	4.99	10,893.14	1.91	52.4
Mentally** Retarded	3,912.80	5.48	21,440.19	1.37	1,437.89	6.97	14.3
Neoplasm	3,201.19	15.71	50,279.10	6.06	16,191.15	1.67	63.7
Allergic	4,674.48	10.41	48,673.76	2.13	5,295.51	4.47	22.4
Blood Disease	3,674.42	12.45	45,734.31	3.01	7,377.48	3.17	31.6
Nervous System Disorder	3,598.16	9.21	33,118.70	2.75	6,204.78	3.46	28.9
Cardiac Condition	3,128.96	13.68	42,805.48	4.67	11,805.74	2.04	49.0
Respiratory Disease	3,608.95	13.37	48,236.08	3.20	7,936.10	2.98	33.4
Digestive Disease	3,173.33	10.85	34,441.07	4.43	10,887.02	2.15	46.5
Genito-Urinary Conditions	5,081.05	9.06	45,972.56	1.58	2,834.73	6.03	16.6
Speech Impairment	3,910.20	7.80	30,671.18	2.45	5,704.85	3.86	25.0
Other Disease	3,440.57	10.79	37,130.85	3.12	7,289.02	3.05	32.8
All Agency	3,348.07	11.44	38,290.94	3.32	7,758.28	2.87	34.8

**See Tables 8 for expanded data on these Disability Groups.

*Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of these future benefits.

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Table 8: Minnesota DVR FY 81 Economic Analysis by Mental, Psychoneurotic, and Personality Disorders

Type of Disorder	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit[a]	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Psychotic Disorder	$2,947.59	9.85	$29,029.53	3.72	$8,005.10	2.56	39.1
Psycho-neurotic Disorder	2,973.79	12.16	36,156.18	5.78	14,213.28	1.64	61.0
Other Mental Disorders							
Alcoholism	2,053.89	20.81	42,737.03	6.51	11,310.27	1.46	68.5
Drug Addiction	2,845.99	18.03	51,304.20	5.34	12,346.84	1.78	56.2
Other Behavior Disorders	3,376.00	12.25	41,391.73	3.95	9,952.50	2.41	41.5
Mental Retardation							
Mild Mentally Retarded	3,627.89	7.18	26,037.16	2.07	3,877.22	4.00	21.7
Moderate Mentally Retarded	4,120.94	4.42	18,197.80	.86	(- 562.07)	11.03	9.1
Severe Mentally Retarded	4,665.68	1.94	9,033.82	.11	(-3,160.09)	84.58	1.2

[a] Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of those future benefits.

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Table 9: Minnesota DVR FY 81 Economic Analysis by Sex

Sex	Average Cost Per Rehab.	Clients' Income Cost/Benefit Ratio	Average Total Client Benefit*	Taxpayers' Payback Cost/Benefit Ratio	Taxpayers' Net Profit* Per Rehabilitation	No. of Years Required to Repay Cost	Annual Rate of Return (%)
Male	$3,208.00	12.06	$42,303.67	3.41	$7,896.15	2.79	35.8
Female	3,474.02	9.18	31,884.50	3.17	7,538.74	3.00	33.3
All Agency	3,348.07	11.44	38,295.94	3.32	7,768.35	2.87	34.8

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* Client and taxpayer monetary benefit, resulting from Vocational Rehabilitation over the remaining working life of the rehabilitated person, have been documented to estimate the present value of these future benefits.

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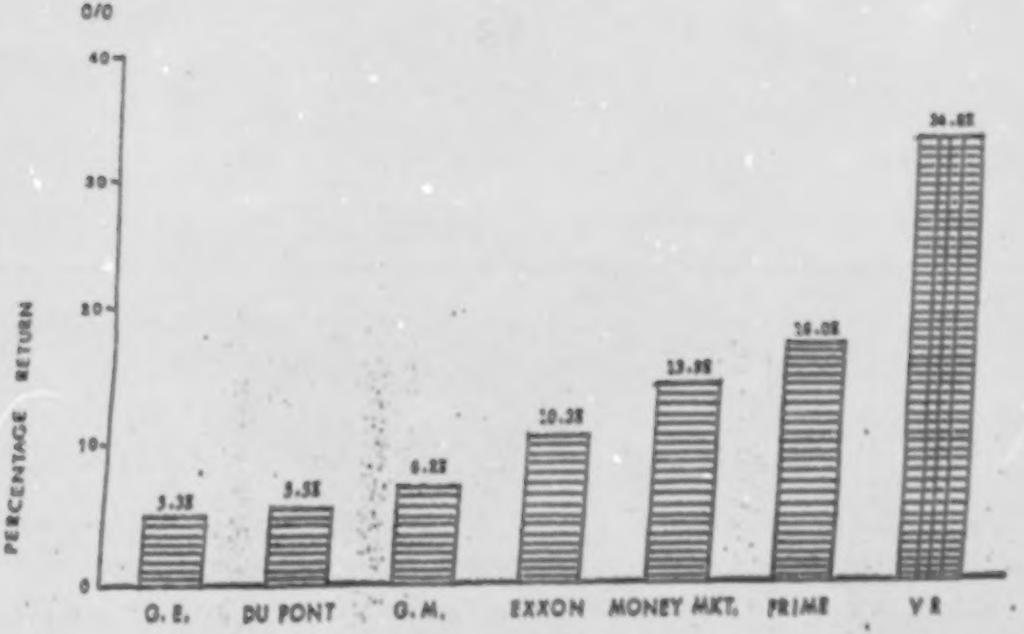
CURRENT RATES OF RETURN ON SELECTED INVESTMENTS
as of March 10, 1982



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INDEPENDENT LIVING CENTERS
in
REGION V

THE ECONOMIC AND SOCIETAL BENEFITS
of
INDEPENDENT LIVING SERVICES

REHABILITATION SERVICES ADMINISTRATION
U. S. DEPARTMENT of EDUCATION
CHICAGO, ILLINOIS

INDEPENDENT LIVING

Control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities. This includes managing one's affairs, participating in day to day life in the community, fulfilling a range of social roles, and making decisions that lead to self-determination and the minimization of physical or psychological dependence on others.

- ILRU Source Book -

A technical assistance manual
on Independent Living Research
Utilization.

The Institute for Rehabilitation
and Research, Houston, Texas
Copyright, 1979

INTRODUCTION

Over the past 50 years the rehabilitation movement has gained recognition as a major force in society's concern for the disabled. During that period of time the emphasis has been almost entirely on vocational rehabilitation or training. Help has usually gone to those who were most likely to become employable, or able to return to work after injury. However, in the last few years there have been increasing expressions by the disabled for recognition of needs beyond employment, such as those related to improvement in their quality of life, the need to be integrated into the mainstream of society or to make meaningful contributions to our nation's well being.

Congress, when amending the Rehabilitation Act of 1973 several years ago, expanded it by adding Title VII, Comprehensive Services for Independent Living. This timely action has brought about great progress toward independence for that part of the disabled population which had previously received little attention and few specific services. Through the authorization of financial support, independent living services to the severely disabled became a reality.

The appropriation of funds to implement Part B of Title VII made possible the establishment of Centers for Independent Living, staffed largely by the disabled themselves. Such services as peer counseling and advocacy, assistance with housing and transportation, personal care assistant programs and independent living skills have thus been made available to the severely disabled.

A brief overview of how those funds have been used over the last three years will be found in the pages that follow. The achievements recounted here have been made possible by Federal legislators who recognized the basic human need for independence and took action. It is a heartening story--a testament of indomitable human courage in the face of what often seem to be insurmountable obstacles.

Ralph A. Church

Ralph A. Church
Regional Commissioner, RSA

ACKNOWLEDGEMENTS

This project was made possible through the cooperation of staff members at the following Centers for Independent Living. Their efforts in providing case histories and background information are much appreciated.

ILLINOIS

Access Living, Chicago

Rockford Access and Mobilization Project - RAMP, Rockford

MICHIGAN

Rehabilitation Institute CIL, Detroit

Center for Independent Living, Grand Rapids

Kalamazoo County CIL, Kalamazoo

Midland Independent Living Center, Midland

Mid-Michigan Urban CIL, Lansing

Northern Michigan Rural CIL, Gaylord

MINNESOTA

Rural Enterprises for Acceptable Living - REAL, Marshall

Rochester CIL, Rochester

Metro CIL, St. Paul

OHIO

Services for Independent Living, Euclid

WISCONSIN

Stout Program for Independent Living, University of Wisconsin, Menomonie

Theodore J. Witham and Helen Kupper, Project Directors
Helen Kupper, Editor

December, 1982

FOREWORD

In today's world, with its concern for shrinking resources of every kind, everyone eagerly looks for bright spots in an otherwise rather gloomy picture. This is especially so for those in the social service field, who are feeling increasing pressure to justify their existence, particularly in the fiscal area. The "bottom line" is more and more being used as the yardstick against which their work is measured. Is it cost effective? - is the recurring question.

To keep a sense of perspective we must remember that our society views itself as one which traditionally has looked after the less fortunate and has not grudged the effort and the cost. Of late, however, the social and economic climate having changed somewhat, the beleaguered taxpayers expect more accountability and justification for social expenditures.

What follows is documented information to support the position that such expenditures, made through the Independent Living movement, are cost-effective in the best and broadest sense. Many of these vignettes, faithful presentations of data gathered from a number of Centers for Independent Living in Region V, are truly financial "success stories," demonstrating striking reductions in cost after the clients received independent living services. While others may show a cost increase, usually relatively small, they are nonetheless successes. In some cases, the greater outlays represent a short-term expense for training and/or medical and personal-care assistance that will ultimately result in real independence through employment. In still others, what has been achieved is an improvement in quality of life, giving less fortunate human beings hope for the future and helping those who are unable to help themselves. If any lesson can be drawn from these accounts, it is that there is no single way to assess the value of the multi-faceted Independent Living movement.

Everyone has heard or read that able-bodied people only temporarily possess that happy state, and accident or disease or age will almost inevitably take its toll. When--or if--that day arrives, it will be encouraging to know that Centers for Independent Living and their skilled, compassionate staffs are available for essential services.

Following the profile of Region V CILs are brief stories about consumers who have used their services. The stories are essentially true, though the names are all fictitious, a few details have been changed and locations omitted to preserve privacy.

INDEPENDENT LIVING IN REGION V - A PROFILE

In the six states of Region V there are twenty-three Independent Living Centers funded by the authority of Section 711 (Title VII, Part B) of the Rehabilitation Act of 1973, as amended. Their programs are dedicated to the development and provision of a variety of services which will assist severely handicapped persons to realize the goal of maximum individual independence. Consequently, the programs have been developed to serve the most significant identified needs of disabled consumers in each community. This grass-roots response to particular needs has provided a rich and diverse offering of special services within Region V.

A lengthy and individual description of each program would be necessary to depict completely the total independent living effort in the states of Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin; therefore, only some general characteristics of the centers are provided.

Most of the centers receive Rehabilitation Services Administration (RSA) grant funds on a contract basis from the State Vocational Rehabilitation agencies. In all states but Indiana, the state agency is the recipient of the RSA grant. In the two state agencies serving the blind and visually impaired (Michigan Commission for the Blind and Minnesota State Services for the Blind), direct administration of center programs is maintained.

The majority of centers in Region V are consumer-based, consumer-managed and consumer-staffed. Many are free-standing private, not-for-profit corporations and are not affiliated with established organizations or agencies. Several have organizational relationships with established rehabilitation centers or other rehabilitation organizations. In one instance the affiliation is with a state university. In all centers there is preponderant consumer policy input and control in the administration of the programs.

The first center became operational in September, 1979 and all others received initial grant/contract funds in 1980 and 1981. The seven services most frequently offered are: information and referral; personal care attendant programs; peer counseling; housing assistance; transportation assistance; independent living skills and advocacy services.

A wide range exists in size of staff, funding levels, number and types of disabilities served, services provided and other characteristics. Nowhere is the extent of that range more clearly shown than in staffing statistics. Full-time staff totals range from one center with 21 to one center with none. The average is about five to a center. The utilization of part-time employees shows a maximum of eight in one center to--once again--one center with none. On average, there are fewer than two part-time staff persons to a center.

The following tables show sources and levels of support:

Table I

Funding Source*	
Title VII, Part B	23
State funds	9
Private funds	8
Other	7

* Total exceeds 23 because some centers have multiple sources of support

Table II

Annual Budget	
Up to $30,000	1
$30,000-60,000	5
$60,000-100,000	6
$100,000-200,000	8
Over $200,000	3

The following information, provided through one state's assessment of the five centers under its contract management during a six-month period, is not necessarily representative, but may be useful in understanding the nature and especially the scope of center activities.

Of a total of 799 consumers who came to the centers for services, 301 were served and terminated and 394 remain for more prolonged assistance. The others withdrew before any service was given. Following are several characteristics of these persons and their distribution as a percentage of the total group served:

Table III

Major Services Provided

Service	Percent
Housing	19.0
Community living skills	14.0
Attendant care	8.0
Leisure & recreation	7.0
IL skills	7.0
Transportation	7.0
Peer/family counseling	6.0
Health maintenance	6.0
Pre-voc./vocational	6.0

Most of those served (83%) ranged in age from 20-69. The largest sub-group (26%) were 20-29 years old, clearly an optimum age-range for maximum long-term benefits to society.

Table IV

Disabilities Served

Disability	Percent
Visually impaired	5.3
Hearing impaired	8.5
Cerebral palsy	10.9
Cardiac conditions	8.0
Spinal cord injury	17.7
Arthritic/rheumatic/ other orthopedic	6.6
Mental retardation	3.3
Mental illness	2.1
Other	37.6

Table V

Education (Years of school)	
5-8 years	13.0
9-12 years	58.0
13-16 years	24.0
Not reported	5.0

Of those served, 66.7% were considered to have shown improvement at time of closure, 26.5% were not improved and improvement could not be determined for 1.3%. In 5.5% of cases improvement was not a reported item.

Of considerable significance were changes in residential status during the course of service:

Table VI

Status	Percent at Referral	Percent at Closure	Difference
Hospitals/alcohol/ drug centers	10.5	4.9	- 5.6
Nursing homes	7.6	6.3	- 1.3
Community residential facility	2.0	1.0	- 1.0
Special arrangements	.8	1.3	+ .5
Parent/relative's home	22.0	12.0	-10.0
Own home	52.0	68.0	+16.0
Unreported	5.1	6.5	

While most of the reductions in the right-hand column indicate only modest improvements in clients' living situations, the large increase in the "own home" category represents one of the major triumphs of the independent living program. The movement of disabled persons from dependent life-styles to independence is nowhere more dramatically shown than here.

This brief description of some characteristics and benefits of independent living centers provides only a "snapshot" of the activities and programs currently in operation in Region V. It is intended to be only an informational starting point; a more comprehensive and sophisticated analysis of the programs and outcomes must await the development and implementation of a uniform data base. Other human service programs have taken years to develop and refine a useful data base. This makes it more remarkable, then, that programs of independent living which have existed for only two to three years can show evidence of such substantial progress despite extremely limited resources.

The vignettes that follow are true stories about real people. Reading them will give a vivid picture of the human aspect of independent living services--essentially what the program is all about.

Dan became a quadriplegic at age 17 because of an automobile accident. Following lengthy physical rehabilitation he returned home, where his over-solicitous-family prevented him from using the skills he had learned during the rehabilitation process. His feeling of uselessness increased to the point that he became suicidally depressed.

Through the help of the State Vocational Rehabilitation (VR) agency Dan was able to complete high school work and receive his certificate of General Education Development (GED). Subsequently he was evaluated and judged to have little vocational potential.

After a time Dan made an attempt to live on his own, but through lack of sufficient self-care knowledge he developed severe decubitus ulcers and was forced to return to a full-care situation. Because he thought it would be less restrictive than being with his family he chose a nursing home, but soon found there was little difference.

About a year ago Dan learned about the CIL in his city through publicity about the center's outreach program. The staff there provided independent living skills training and counseling to motivate him to adhere to his mandatory self-care program. They also located an accessible apartment, federally-subsidized through Section 8 of the Housing Assistance Payments Program for Lower-Income Families, U. S. Department of Housing and Urban Development and found a suitable personal care assistant.

Despite his limited physical function, Dan has been living independently for some time, requiring only minimal assistance in performing the necessary physical and logistical tasks. He also has become a volunteer for the center, working as a peer counselor and providing orientation to PCA trainees, activities that have increased his sense of personal worth.

With the encouragement of a center staff member Dan, now 34, has decided to enroll in the local community college to work toward a degree as a paraprofessional in human services. Thus, through services provided by a center by independent living, this young man's life has been completely turned around. From a totally dependent, depressed individual with little to look forward to, he has become a contributing member of society, with better days ahead.

Dan himself describes the difference this way: "I have the freedom to use my mind again and make my own decisions, right or wrong."

LAST YEAR		THIS YEAR	
SSDI*	$ 2,340	SSDI	$ 2,340
Medicaid	600	Personal care assistant	4,342
Nursing home	14,965	Medicare/Medicaid (Medicine, wheelchair etc.)	700
		Rent (subsidy)	3,600
Total	$ 17,905	Total	$ 10,982
		Difference	$ 6,923
			-39%

* Social Security Disability Insurance

Emily, who is mentally retarded and has severe visual impairment, was graduated from high school after completing a special education curriculum. During her school years she lived in several foster homes; after graduation she went to live in the county health care center.

Less than a year ago, a university-affiliated independent living program selected 21-year-old Emily for training to live in a partially independent environment. She now lives and actively participates in a cooperative housing arrangement in which three developmentally disabled clients and two university students share common household duties and assume responsibility for their personal tasks, such as cooking and laundry. The students serve as role models and provide crisis intervention.

She has also been admitted to a sheltered workshop, where she is receiving pre-vocational training. Emily's potential is now judged to be such that after another year to a year and a half of developing good work skills and appropriate social behavior she will be a good candidate for competitive employment.

On-going counseling and training in such independent living skills as money management and budgeting, cooking, using public transportation and planning use of leisure time have increased Emily's sense of personal worth and greatly improved her quality of life. Those who are working with her anticipate that after perhaps two years in her present living and working situation she will be capable of living as an independent individual.

LAST YEAR		THIS YEAR	
SSI*	$ 4,608	SSI	$ 4,608
Health care center	14,027	Medicaid	144
		Sheltered workshop wages	192
Total	$ 18,635	Total	$ 4,944
		Difference	$ 13,691
			-73%

* Supplemental Security Income

Severely disabled by cerebral palsy, Norman lived at home, where his mother provided the full range of personal care and daily living services. Although he attended special schools he never learned to read and his parents did not encourage him to become involved in any community activities.

When Norman reached age 21 he moved to a nursing home in an attempt to become more independent. That this course of action did not satisfy his needs is obvious; in ten years he lived in eleven different nursing homes. He also made one brief try at apartment living, but lacking survival skills he was forced to return to the home.

About a year ago Norman came to the independent living center in his city for help with still another venture at living on his own. The staff assessed his multiple needs: training in personal care and independent living skills; learning to read; financial assistance and accessible housing.

He was referred to the occupational therapy program at a rehabilitation hospital, where he was trained in the use of adaptive equipment to enhance his daily living skills. At the center Norman attended a number of independent living seminars, covering such topics as human potential; personal care assistant (PCA) management; self-help aids in homemaking; self-image and sexuality; and nutrition.

Within three months he was able to move into a supportive living arrangement and now shares a federally-subsidized apartment with another disabled man. He has hired and manages a PCA who supplies personal care and homemaking services. By attending a center program of services for work and rehabilitation he is continuing to upgrade his independent living skills, he is learning to read and is receiving pre-vocational training.

Moving from a dependent environment to his present situation has given Norman an appreciation of his freedom to establish social relationships by getting out in the community. He now has goals: to complete a high school equivalency program and get his GED, and some day to obtain competitive employment.

Norman's definition of independent living: "To work and live on my own."

LAST YEAR		THIS YEAR	
SSDI	$ 4,992	SSDI	$ 4,992
Nursing home (Medicaid)	10,450	Personal care assistant	6,114
Hospital (Emergency care)	4,400	Medicaid/Medicare (Wheelchair repair, medicines, etc.)	300
Wheelchair costs	300	Rent (subsidy)	2,948
Total	$ 20,142	Total	$ 14,354
		Difference	$ 5,788
			-29%

Melanie, 42, has a long history of mental illness for which she has been hospitalized numerous times. Two years ago she was released from a state hospital psychiatric ward with few survival or coping skills and encountered severe financial and interpersonal problems.

Initially she came to the CIL for assistance in resolving a dispute with her landlord. Staff then helped her to be assigned to a different psychologist at the local mental health center. Further efforts on Melanie's behalf have included money management and assertiveness training and other related independent living skills. She is learning how to take charge of her life: to be responsible for monitoring her physical health, to recognize when she needs professional help for emotional problems--and to get it.

Melanie has been married and divorced and receives $250 a month in alimony. This is her only income, as this amount has made her ineligible for any public assistance--Medicaid, SSI or food stamps. She stretches her meager income by sharing living quarters with three other mentally or physically disabled persons and by canning much of her own food from end-of-the-day giveaways at the local farmers' market. For a little additional cash she scavenges pop-top cans to sell for recycling; except that she has a place to live, she could be called a "bag lady."

Probably it is through the intervention and support services she has received from the center that Melanie has been able to survive outside of an institution. Even discounting her personal preference for living independently, albeit in poverty, Melanie's experience is a real "success story" for the taxpayers. The cost comparison below shows dramatically the benefits to society realized through CIL services.

TWO YEARS AGO		THIS YEAR	
State hospital (custodial care)	$ 30,002	Counseling (Social worker at welfare office, est.)	$ 720
Psychiatric care/ medications	13,433		
Total	$ 43,435	Total	$ 720
		Difference	$ 42,715
			-98%

Injuries sustained in an automobile accident seven years ago left William a quadriplegic. He was 14 years old.

After finishing school he became a client of the State rehabilitation agency and successfully completed training as a computer programmer. He obtained employment in that field and bought a van which was fitted with adaptive aids by the VR agency. This enabled him to get to and from work independently.

Because he was unaware of other options, through these years William continued to live in the family home, with his father supplying the needed attendant care. About a year ago, at the suggestion of a family member, William came to the CIL in his city to explore the possibilities for living more independently.

The center provided referrals to varied sources of help: affordable, accessible housing; a credit agency for a loan for initial expenses of establishing his own residence; possible avenues for locating personal care assistants.

For almost a year now, William has been living in a barrier-free, Section 8, federally-subsidized apartment, with a live-in personal care assistant on a room-and-board-for-services arrangement. He is also becoming active socially; one of his greatest pleasures is going camping with his girlfriend.

While there is no direct, immediate dollars-and-cents benefit to taxpayers in this story, benefits to society are incalculable--and obvious: William, at age 21, has progressed to a higher level of independence through the services of a CIL and will have a productive, self-reliant life. As his skills and income increase, the present taxpayer subsidies will no longer be necessary. His family, especially his father, surely is pleased at his present accomplishments and his brighter future, as well as relieved of a physical burden that would have become increasingly difficult to sustain as the years pass.

Marjorie is 32 years old and has a progressive neuromuscular disease which so far has defied precise identification. The disorder has forced her to use a wheelchair for the past four or five years.

When she first learned about the CIL in her city she was living in an unsuitable apartment, had no knowledge of available transportation services, had no plans or goals and was extremely depressed.

Since utilizing the center's services Marjorie's life situation has undergone a striking change. She now lives in a Section 8, federally-subsidized, accessible apartment; through counseling she became aware of her rights as a disabled citizen and is an effective self-advocate; she has learned about and frequently uses the city's bus service for the handicapped; she has enrolled in junior college to become an occupational therapy assistant; to the degree her physical condition permits she is active in a sports program at the center; and she contributes as a volunteer to the center, working on the newsletter and doing telephone research to locate accessible housing for other CIL clients.

In this story about Marjorie it is difficult to present accurate before-and-after costs. Some "before" information is not available, e.g., medical and surgical costs paid through Medicare/Medicaid. Certain "after" costs are difficult to assess also, such as how much Marjorie's use of the bus system costs the city, or the total financial assistance she receives from the junior college, both in tuition and Handicapped Student Services time.

While it would be gratifying always to be able to point to substantial dollar savings, at times there may be either a trade-off or even an increase of costs through the intervention of independent living specialists. In Marjorie's case this may be a short-term increase in order to get eventual long-term reduction of taxpayer burden. However, as the comparison below shows, the progressive nature of her disease has required additional services (homemaker care).

Even if her future condition calls for still more assistance, as long as Marjorie can remain in her own apartment her total maintenance cost will be substantially lower than that in a nursing home, which would total, at a minimum, $18,000 to $20,000 annually.

LAST YEAR		THIS YEAR	
SSI	$ 3,708	SSI	$ 3,708
Homemaker care	-0-	Homemaker care	3,360
Rent (subsidy)	2,376	Rent (subsidy)	3,132
Total	$ 6,084	Total	$ 10,200
		Difference	$ 4,116
			+68%

Because of severe cerebral palsy, Lillian had spent the last 14 years in a nursing home. Eight months ago, at age 39, she requested admission to a center for independent living. This CIL is associated with a rehabilitation institute (part of a major urban medical center), and offers residential services and training.

Lillian's strong motivation and eagerness to learn practical, fundamental skills enabled her to make rapid progress and to gain needed confidence and self-reliance. After two months, she had acquired such personal care competence that her need for assistance was reduced by half. Indeed, she progressed so rapidly that she completed the usual six-month course in four months.

In spite of extreme spasticity, Lillian gained independent living skills to such a degree that she is now living in a federally-subsidized (Section 8), barrier-free apartment, virtually independent. Her only needs are part-time personal care assistance and help with heavy housecleaning.

The CIL provided services and training in the whole range of independent living skills, among them cooking; cleaning; personal care assistant management; health and hygiene; leisure planning; assertiveness and advocacy training; and physical fitness. Having achieved such competence in daily living, Lillian is now receiving help in remedial reading and writing and is looking toward the possibility of vocational training some time in the future.

This account of how Lillian moved from complete dependency to virtual autonomy, with every reason to hope for a better future, is a success story about society's care of the less fortunate. However, society is also concerned about what it costs to achieve these triumphs. The chart below gives striking evidence that in many cases it is not only socially, but also fiscally desirable to make such successes possible. Finally, no matter which way the benefits may be viewed, if Lillian were asked she might say that for her, Life Begins at Forty.

LAST YEAR		THIS YEAR	
SSDI	$ 3,720	SSDI	$ 3,984
Medicaid	6,012	Personal care assistant (15 hrs/wk)	2,478
Nursing home	14,950		
		Rent (subsidy)	3,204
Total	$ 24,682	Total	$ 9,666
		Difference	$ 15,016
			-61%

Walter, who is legally blind, lives with his wife in a senior citizens apartment complex. Within the last year his need for cataract surgery became acute--he could distinguish only between light and dark--and his hearing deteriorated to almost total deafness.

Because of his limited income, Walter could afford neither the cataract surgery, estimated to cost about $2,500, nor a new hearing aid at approximately $200. The combined handicaps obviously presented serious obstacles to physical and social functioning. Lacking improvement in his condition, a mova to a nursing home seemed almost inevitable.

At this point the CIL in his city became involved. The staff obtained diagnostic evaluations and for $229 purchased a hearing aid which brought Walter's hearing up to normal. The center also secured financial assistance totaling $700 from the local Lions Club to supplement the Medicaid payments for surgeon's fee and hospital costs for the cataract surgery.

As a result of these services Walter is functioning quite independently; even if his wife could no longer help him he would probably be able to remain in his own home. His improved condition has also enabled him to resume his former leadership position in the organization for the blind in his city.

Thus, through the expenditure of $812 from the center (hearing aid and diagnostic tests) and $700 from the Lions Club (cataract surgery), a previously active and involved older citizen was enabled to become so again. In addition, by virtually eliminating the need for institutional care, the center, through its efforts, has achieved significant cost avoidance: a conservative estimate places the cost of such care at no less than $16,000 a year.

Jennifer is a young woman of above-average intelligence who has moderately severe speech and mobility problems because of cerebral palsy. She does not articulate clearly and uses a walker. These limitations made her unsure of her ability to succeed in college, so after graduation from high school she remained at home and entered a sheltered workshop program, doing general office work.

Nearly a year ago she attended a workshop on independent living at the local CIL. Meeting and talking with other attendees, some more severely disabled than she, Jennifer realized that taking charge of her own life and taking risks was something she could do. She began by inviting other disabled persons to join with her in a social club and she received a positive response. From this she has progressed to training in the center's peer counseling program, with emphasis on social and recreational program ideas.

The encouragement the center has given Jennifer has enabled her to take a big step forward. This fall, at 26, she enrolled in a nearby college, with a tentative career goal of rehabilitation counseling. Every day brings more self-confidence as Jennifer learns how to make adult, independent decisions about herself--now and for the years to come.

Cost savings are difficult to compute. Jennifer will remain at home for the present; since she has been in a subsidized workshop and is receiving financial assistance in college, taxpayer costs will probably remain fairly constant.

However, her future earning power will be substantially greater after achieving a college education, so she can become a fully contributing member of society.

Inevitably, Jennifer's parents will some day be unable to take care of her. And then, lacking survival skills, she would be completely dependent on custodial care in an institution. However, with the impetus and training furnished by the center, she has taken the risk to develop her potential--and she can face the future with optimism.

As the result of an automobile crash on his high-school graduation night, Tim has been a quadriplegic for 23 of his 40 years. After a fall early this year, he was hospitalized for six months. When he was ready for discharge he had nowhere to go, as his room in a group home was no longer available.

There were several obstacles to be overcome at that time. Because he no longer required medical care Tim had to leave the hospital within two weeks; the hospital was 100 miles distant from his home city, making the housing search more difficult; if no suitable housing could be found, the only alternative was placement in a nursing home, a solution previous experience had made unacceptable to him because of "age difference and emotional trauma," in his words.

At this point, Tim was referred to the CIL in his city. In a race against time, center staff obtained an accessible unit in a newly-opened federally-subsidized housing complex and helped Tim move in a day ahead of the hospital discharge deadline. Subsequently they helped him find permanent live-in attendants and obtain Title XX (Social Security Medicare) funds to pay for housekeeping services in his apartment.

At one time Tim had operated a small business, but when that was no longer feasible, the State Division of Vocational Rehabilitation made it possible for him to attend college.

He is majoring in rehabilitation counseling and expects to get his bachelor's degree in about two years.

The figures below show substantial current cost reductions in Tim's living situation achieved through the CIL's efforts. It is also clear that in the future, because of services he is receiving from DVR, Tim will become a truly independent, tax-paying citizen.

LAST YEAR		THIS YEAR	
SSI/SSDI	$ 3,648	SSI/SSDI	$ 3,648
Nursing home care	29,172	Rent (subsidy)	3,600
Medications	780	Attendant care	12,000
		Chore services	6,000
		Medications	540
Total	$ 33,600	Total	$ 25,788
		Difference	$ 7,812
			-23%

Howard's elderly parents, in failing health, were concerned about his future when they could no longer provide around-the-clock care for him. Mentally retarded and with multiple physical problems, 46-year-old Howard had lived at home all his life.

When his family enlisted the assistance of the local CIL nearly a year ago, it was clear that Howard needed the full range of its services, as family members had relieved him of all responsibility for his own survival duties. Staff at the center located an accessible, federally-subsidized apartment and trained Howard in the daily living skills he needed to maintain himself in it. He also learned to use the city transportation system and to do his own shopping. Functioning at a higher level than ever before, Howard has established social relationships with his neighbors and participates in a bowling league.

While he has never been employed and vocational prospects are not bright at present, his marked improvement in social functioning and competence in living independently suggest the possibility that a vocational goal may be attainable one day.

Whatever the future may bring, Howard's family are relieved that he is now in a suitable living situation and competently managing his own affairs. Indeed, one family member, impressed with the value of the CIL, has become a volunteer, locating housing for center clients.

Although the cost comparison below shows a present increase, it is minimal compared to what it would be if Howard, lacking independent living skills, were forced to enter a nursing home for custodial care. Present cost of maintenance in an intermediate care facility is conservatively estimated at $15,000 to $20,000 annually.

LAST YEAR		THIS YEAR	
SSI/SSDI	$ 5,052	SSI/SSDI	$ 5,052
Rent (subsidy)	-0-	Rent (subsidy)	3,552
Medical care (covered by family policy)	-0-	Medicaid	384
Total	$ 5,052	Total	$ 8,988
		Difference	$ 3,936
			+78%

Suzanne has been paralyzed on the right side of her body following a stroke 13 years ago. She has been living in a nursing home ever since, confined to a wheelchair. She is very soft-spoken and has some speech difficulties.

Although she has independent living skills, and at first thought she wanted to attempt apartment living with a personal care attendant and homemaker services, Suzanne, now 55, felt unsure of her abilities after so many years of dependency. For the present, therefore, she opted for a transitional living situation, with roommates who are also disabled. Attendant care and homemaker support are available around the clock.

The center gave her information on housing and attendant care possibilities; the center worker thinks that in a year or two she will quite likely be on her own, as her feeling of capability increases. A measure of Suzanne's growing self-confidence is that her reluctance to use the phone because of her speech problems seems to be lessening. As her speech improves, she uses the phone more and more, one indication of life-quality improvements attributable to independent living services.

LAST YEAR		THIS YEAR	
SSDI	$ 420	SSDI	$ 3,408
Nursing home	17,338	Attendant care	10,800
		Medicaid (medicine)	480
		Rent (subsidy)	852
Total	$ 17,758	Total	$ 15,540
		Difference	$ 2,218
			-13%

Despite the effects of multiple sclerosis, which have left her legally blind and a double amputee confined to a wheelchair, Myra has maintained her independence and lives alone in her own home. She must also cope with many other medical problems, including pulmonary difficulties that are aggravated by heat and humidity. To enable her to remain at home, her doctor recommended the installation of a room air conditioner.

As a client of the State Commission for the Blind, learning handicraft and homemaker skills, Myra tried first to obtain the appliance through that agency. However, the equipment was not deemed necessary for her to complete her program and achieve her vocational goal.

Myra then turned for help to the CIL in her community, as the "agency of last resort." Staff there were able to obtain funding from the National Multiple Sclerosis Society for two-thirds of the cost of the air conditioner, with the Commission for the Blind supplying the balance. Through the CIL's timely intervention and imaginative approach to locating the resources, Myra was able to remain in her home and continue her rehabilitation plan without undue stress during the hot and humid months.

Thus a total expenditure of $460 for the air conditioner ($295 from MS, $165 from the State agency) helped an independent, 39-year-old woman remain so, to her own and society's benefit. The comparative chart below shows approximate maintenance costs for Myra in her own home versus what it would cost, likely for many years, had she been forced to move to a nursing home. Thus, this success story is not one of cost-reduction, but of cost-avoidance.

DEPENDENT		INDEPENDENT	
Social Security (survivor's benefits)	$ 4,068	Social Security (survivor's benefits)	$ 4,068
Nursing home (Medicaid, incl. supplies/medicine/doctor)	11,940	Medicaid (supplies, medicine/doctor)	1,800
Total	$ 16,008	Homemaker assistance	2,520
		Food stamps	432
		Total	$ 8,820
		Difference	$ 7,188
			-45%

When Ethel was six years old she became a quadriplegic as the result of an attack of polio. After finishing high school she became a client of the State Vocational Rehabilitation agency and completed university training as a rehabilitation counselor. Throughout these schooling years she lived at home, where her mother attended to her personal care needs, encompassing the full range--bathing; dressing/undressing; bed and wheelchair transfers; meal preparation; housekeeping; transportation, etc.

About a year and a half ago Ethel, then 33, found a counseling position that made it necessary for her to move from her parents' home to an apartment closer to her job. At her request, the CIL in her city helped her to locate an accessible apartment and subsequently was instrumental in finding appropriate candidates to satisfy her need for a permanent personal-care assistant.

Ethel's income is too high for her to receive Medicaid/Medicare services, so the center's attendant care coordinator explored other options with her. She then found a suitable live-in attendant in exchange for room and board plus much free time during the day.

In addition to supplying her housekeeping, health and personal hygiene needs, Ethel's attendant drives her to and from work in the used, fully-equipped van Ethel has purchased from her earnings.

This up-beat story is one to hearten everyone in the social service field, and to encourage the heavily-burdened taxpayer as well. Without the support and training supplied by VR and the services and creative alternatives offered by the center for independent living, this severely-disabled woman would probably have spent her life completely dependent on her family--and later, the taxpayers. Instead, Ethel is a contributing, tax-paying member of society, successfully leading an independent life.

DEPENDENT		INDEPENDENT
SSI	$ 3,000	None
(No other taxpayer costs, as she lived with her parents.)		

Anna, who is in a wheelchair, was living in a county medical care facility because of multiple physical handicaps--diabetes, severe visual problems and suspected multiple sclerosis. About a year ago, at age 37, she decided to make an effort to become more independent, and requested help from the CIL in her city. The staff furnished training in independent living skills, much needed because she had never lived alone, helped her to locate an accessible apartment and made sure she received a low-vision evaluation.

Anna is now living on her own in an accessible apartment, doing her own cooking and most of the cleaning, administering her own medication, handling her personal finances, and performing other tasks appropriate to living independently. Although her vision is still very limited, her functioning has greatly improved because she has three new pairs of glasses. These were acquired through the efforts of the CIL, which obtained financial support of $400 from the local Lions Club. In short, Anna is living virtually on her own, with some assistance in transportation and shopping supplied by friends.

She is also active in her church, running Sunday School sessions and helping with Bible study classes. Anna plays the piano and with a musical group regularly visits several nursing homes to entertain the patients. She began a steady babysitting job this fall and is carrying out those duties satisfactorily.

Anna's story is unquestionably impressive: within one year moving from total dependency in a nursing home environment to independence--a woman in charge of her life, living alone, helping others and gainfully employed. This is not only a success for Anna, but one for the taxpayers, too, as a reading of the figures below will demonstrate.

LAST YEAR	
SSDI	$ 324
Care facility (Medicaid/Medicare)	22,630
Total	$ 22,954

THIS YEAR	
SSI/SSDI	$ 3,912
Medicaid (medicines/doctors)	780
Medicare	132
Rent (subsidy)	1,440
Food stamps	132
Total	$ 6,396
Difference	$ 16,558
	-72%

On crutches because of cerebral palsy, Betsy, 24, successfully completed college with a bachelor's degree in paralegal studies. Since no jobs were available in her small town, last spring she moved to a nearby large city and requested information on housing and transportation from the CIL there.

Among the services Betsy received were assistance in locating an accessible federally-subsidized (Section 8) apartment, information on the city's bus system for the handicapped, and referral to the State DVR for job training and job placement services.

Having completed the center's training program, Betsy is volunteering as a peer visitor. Now she has started training to learn to counsel center clients in their search for accessible, affordable housing. This will give her a paid, part-time position that will provide valuable work-experience and needed additional income.

At present the state of the economy presents obstacles to Betsy's placement in a position in the paralegal field for which she trained. However, living in a large city gives her the opportunity to take advantage of any openings that may occur. In the meantime, as a satisfied former client, she is contributing skill and enthusiasm to the center, while acquiring useful experience.

While the comparison below does not show an immediate taxpayer benefit, Betsy's improved living situation and availability for future paraprofessional employment counterbalance the temporary increase.

LAST YEAR		THIS YEAR	
SSI	$ 3,180	SSI	$ 3,180
Total	$ 3,180	Rent (subsidy)	2,808
		Total	$ 5,988
		Difference	$ 2,808
			+88%

Mildred spent 20 of her 35 years in a state mental institution, classified as mildly to moderately retarded (mostly institutional retardation) and with emotional problems as well. When she was released about two years ago she had little or no knowledge of how to live "outside." As might be expected, she had many problems with obtaining needed services and establishing friendly social relationships.

After moving to a different city Mildred was totally indigent and lived on park benches--a "bag lady." Later, through the intervention of the person who was designated to manage her social security income on her behalf, she moved into a boarding home. There, with help from the local CIL, she began to learn to manage her money and cook her own meals. As Mildred's skills and self-confidence grew, it was clear she had the capability to live alone. Soon she moved to a federally-subsidized (Section 8) apartment where she is managing to solve her problems--with minimal assistance from the CIL--and is handling her own finances.

At this point Mildred is being tested and evaluated by the State VR agency to assess her capability for employment. She continues to receive counseling through community mental health services, has attended adult basic education classes and is planning to participate in Special Olympics.

She also volunteers at two nursing homes, serving meals and contributing other assistance to the residents.

While the chart below shows no present savings to taxpayers (instead there is an increase) Mildred's experience is a striking example of how a severely disabled person can move from long-term institutionalization and no apparent vocational potential to an independent lifestyle with a good prospect of future employability. When the day comes that Mildred can convert her volunteer services to paid employment, the taxpayers stand to reap a substantial return on society's investment in her.

LAST YEAR		THIS YEAR	
SSI	$ 3,307	SSI	$ 3,468
Medicaid	500	Rent (subsidy)	1,344
Food stamps	288	Food stamps	288
Total	$ 4,095	Total	$ 5,100
		Difference	$ 1,005
			+25%

Twenty-six-year-old Hazel is severely disabled by cerebral palsy. She gets around in a motorized wheelchair which was bought in anticipation of a move to independent living from the rehabilitation center which had been her home for almost two years. Prior to that she had been in a nursing home for seven years, after leaving her parents' home.

Less than a year ago, when she heard about the local independent living center through an outreach program, Hazel immediately requested their services. With the center's help she located an accessible apartment in a housing complex occupied by disabled persons and she has become active in a support group there. She also attends church regularly and goes shopping, community activities she was not able to participate in while living in a nursing home.

The center helped Hazel to learn budgeting and other independent living skills. Very important was counseling in how to structure her days, since a long-term nursing home resident has little idea of how to manage time when living independently.

According to a center staff member who has worked closely with her, Hazel is so severely disabled that she really should have a personal care assistant and homemaker services. However, she is strongly motivated and determined to do everything on her own--and against great odds she is managing successfully.

Hazel now volunteers 25 hours a week at the center, doing peer counseling and receiving on-the-job training in a variety of office skills. She makes phone calls to locate housing and other services for the center's clients, does filing and fills in as receptionist. Estimates are that Hazel will soon be able to work 30 hours a week, using the vocational skills she has been learning, and within five years she will probably be able to work a full 40-hour week in competitive employment.

LAST YEAR	
SSDI	$ 420
Rehabilitation Center	32,850
Total	$ 33,270

THIS YEAR	
SSDI	$ 3,408
Motorized wheelchair*	660
Medicare (wheelchair repair)	300
Rent (subsidy)	2,196
Total	$ 6,564
Difference	$ 26,706
	-80%

* Wheelchair purchase $3,300, average life 5 years. Annual cost $660

AFTERWORD

Human services providers and government agencies are constantly searching for ways to document reductions in taxpayer burden achieved as a result of their program efforts. Precise measurement of such economic benefit is a desirable but elusive goal. Despite the difficulties, however, these accounts demonstrate that significant individual and aggregate benefits are being provided to severely handicapped persons by the 23 Independent Living Centers in Region V.

Part of the difficulty arises from the large variety of problems and disabilities presented to the centers and the broad range of individualized services and programs needed to deal with them. Another obstacle exists simply because independent living is a new program, as social programs go, and has so far developed cost-benefit documentation methods of only limited scope and meaning. A universally-applicable system awaits longer experience and more sophistication in the program.

Our society is founded on certain intangible humanistic values, especially that of individual worth. For the independent living movement to reach its full potential and acceptance, the intangible benefits accruing through its efforts to individuals, families, communities--and the taxpayers--must be recognized. These benefits must then be included as part of the "bottom line" in any assessment of financial cost and benefit.

There is an interesting--and possibly unexpected--aspect of the independent living program emerging through these case histories. The movement was conceived as a means of assisting the isolated severely-disabled into the mainstream, even though no vocational goals seemed realistic. It is now becoming apparent that many heretofore unlikely candidates are moving into programs where employment may be attainable. Thus, this unanticipated development may prove to be one of the most valuable benefits of independent living services.

* U.S. GOVERNMENT PRINTING OFFICE: [illegible]

Promoting Rehabilitation Progress

National Rehabilitation Association

Rehabilitation

A Cost Effective, People Responsive Program

Economic independence for persons with disabilities is the basic goal of the nation's vocational rehabilitation program. Since 1921, a partnership of state, federal and private efforts has made that goal a reality for more than 3.4 million Americans with disabilities.

The partners in vocational rehabilitation get people with mental or physical disabilities back to work. Individualized rehabilitation programs meet the unique needs of each person served. Competent rehabilitation professionals provide job counseling and arrange for job services so that persons with disabilities can become workers and taxpayers. Many who cannot work can live more independently. Rehabilitation is a national investment that pays off!

Each partner plays a vital role in this comprehensive, econcomically sound program.

The **State partner** provides:

- ✓ **state-generated financial resources**
- ✓ **state-level responsiveness**
- ✓ **coordination of local services for maximum cost-effectiveness**

The **Federal partner** provides:

- ✓ **nationwide financial resources**
- ✓ **nationwide, coordinated research and training programs**
- ✓ **nationwide program standards and assurance of access to services**

The **Private partner** provides:

- ✓ **competitive, cost-effective services to aid persons with disabilities**
- ✓ **access to local employers**
- ✓ **community volunteer efforts**

Rehabilitation Works!

Rehabilitation

What It Does For All Of Us

- ✓ **Persons with disabilities achieve greater personal and economic independence.**
- ✓ **Persons with disabilities contribute their time and talents to their communities, as full participants.**
- ✓ **The program is highly cost beneficial: Ten ($10) dollars are returned to state and federal governments for every dollar invested.**
- ✓ **Our nation's economy improves with the utilization of the productivity of persons with disabilities.**
- ✓ **Employers are provided a ready source of trained, willing workers.**
- ✓ **Monies to provide rehabilitation services are spent in local communities throughout the nation.**
- ✓ **As an effective program, rehabilitation acts as a magnet, drawing funds from the private sector.**
- ✓ **As a locally run program with national standards, high quality services are assured, as is the proper use of taxpayers monies.**

The National Rehabilitation Association Its Mission and Purpose

The National Rehabilitation Association (NRA), founded in 1925, is a private voluntary organization whose purpose is to advance the rehabilitation of all persons with disabilities. With a membership, including disabled persons, of over 20,000; the association is an effective advocate for persons with disabilities.

NRA achieves its purpose through:

Legislative Advocacy: including support for the Rehabilitation Act of 1973, as amended and the Education for All Handicapped Children's Act.

Advocacy for the Removal of Barriers: barriers to full enjoyment of the rights and benefits of American citizenship. NRA engages in appropriate court action when needed.

Increasing Public Awareness: of the rights and needs of persons with disabilities.

Improving Professional Skills: by sponsoring educational conferences and workshops, supporting the Mary E. Switzer leadership seminars, publishing the Journal of Rehabilitation, and sponsoring achievement awards.

Promoting High Quality Personal and Program Standards.

NRA operates its programs through seven divisions and state chapters in all states. The national office in Alexandria, Va., provides support and leadership to NRA's action.

National Rehabilitation Association
633 South Washington Street
Alexandria, VA 22314
(703) 836-0850

(4)

NRA's Legislative Priorities

- ✓ NRA supports full funding of **all** programs authorized by the Rehabilitation Act of 1973 as amended.
- ✓ NRA supports strong efforts to assure the basic rights and opportunities for persons with disabilities as embodied in Title V of the Rehabilitation Act and in Public Law 94-142 -- The Education for All Handicapped Children Act. This means:
- ✓ NRA supports efforts to eliminate disincentives to employment of persons with disabilities contained in Social Security programs.
- ✓ NRA supports legislation providing added tax deductions for severely disabled persons, where needed, and tax incentives to employers who hire persons with severe disabilities.
- ✓ NRA supports a variety of programs and rights designed to assure the full participation of persons with disabilities in American society.

Rehabilitation is Cooperation

- ✓ The National Rehabilitation Association maintains cooperative relationships with a wide range of organizations and groups concerned with rights and programs for persons with disabilities.
- ✓ State rehabilitation agencies cooperate fully with programs of health, welfare, education and training in providing services to persons with disabilities.

Rehabilitation is Opportunity

The opportunity for persons with disabilities to full and meaningful participation in all of life's activities.

For More Information: Contact

(c)

Mr. MURPHY. Mr. DeJong.

STATEMENT OF JAMES DeJONG, ACCESS LIVING, CHICAGO, ILL.

Mr. DEJONG. Mr. Chairman and members of the subcommittee, my name is James DeJong. I thank you for inviting me to testify on behalf of the National Council of Independent Living Programs and persons with disabilities.

Presently, 144 centers are operating and funded under title VII, part B of the Rehabilitation Act of 1973 and its amendments. We are deeply committed to the development of a strong and stable base of financial support for community-based independent living centers which serve a cross-disability population and are administered and staffed by persons with disabilities.

To reach this goal, independent living centers must have ample time and funds to establish their programs, train personnel, deliver quality services and establish credibility within their local communities. Only then will we be viewed as a viable and integral part of the rehabilitation process. Only then will we be competitive in obtaining private funding and in the marketing of our services.

Having been with the Chicago program, Access Living, since it was a mere idea to its present state of service, I speak from experience about the need for adequate establishment time. The needs and demands of the community are so great that it takes time to establish priorities and a stable structure to meet those demands.

The purpose of the program of services authorized under title VII is to assist persons with severe disabilities to live more independently in their homes and communities. By increasing these options to persons with disabilities, we are also seeing tremendous savings to the taxpaying public.

Let's look at an example which highlights these savings. Betty and Peggy, both in their late forties with cerebral palsy, had been residing in a nursing home for the past 15 years when they contacted Access Living. Their combined living costs were $27,580 per year. Peer counseling and independent living workshops were provided to both women immediately. A search for accessible, subsidized housing was then initiated, resulting in these two women moving into the community, sharing an apartment.

By also being able to share personal care assistance costs, these two women have reduced their costs to $20,956 per year. Peggy's and Betty's experience resulted in a total savings of $6,954 per year to the taxpayer. If this story were repeated for half of the 22,000 plus nonelderly disabled residing in Illinois nursing homes, it would be a phenomenal cost saving to society.

This figure does not reflect the enhanced lifestyle or quality of life now experienced by these two persons. Our independent living center succeeded where efforts by others in the previous 15 years had failed.

Experiences like this are occurring in each State, in each major city and in each rural area where an independent living center is operating. The names may differ, the disability may vary, but the improved life options and the related savings continue to mount throughout our country.

We are a relatively young program, but we have already seen the growth of a strong commitment from persons with disabilities and the entire community for the alternatives independent living provides.

The business community has found the independent living centers to be a valuable resource, also. For example, in one major city a large corporation recently contacted the local independent living center to learn about accessible design and to provide sensitivity training for their employees. The personnel department requested this training so disabled and able-bodied persons could work more comfortably and productively together.

The independent living center presented workshops and one-on-one consultation to this company over the past year and now I am happy to say the corporation has an accessible facility and a progressive, open policy toward hiring persons with disabilities.

This example shows the versatility of services offered by independent living centers which benefit persons with disabilities and in turn reward and benefit society at large.

Our services offer an exciting and important opportunity to our entire society. We urge you to allow this important progress to continue and grow by providing adequate funding to title VII, part B, maintaining existing centers and allowing for the development of new centers in areas which demand their existence.

We also hope you will see the funding of part A as an immediate priority so independent living centers are able to make the transition successfully away from the part B moneys. Only then will there be a coordinated, economical plan to insure the continued existence of your investment in independent living. To have any machine working efficiently, one must have all the parts functioning well.

We also take this opportunity to urge you to continue the title I program as it is presently administered and funded. It has made the work of independent living centers easier and more proficient. We also support the research and training centers, so they may develop effective evaluation methods to continually improve our understanding and service delivery to persons with disabilities.

In conclusion, the independent living movement for severely disabled people is far too important for us to allow it to diminish. It is still in its early stages and needs Government support to enable it to reach its full potential.

We seek your continued support to assure the future of independent living by increasing title VII funding and to fund part A. You have demonstrated your commitment in the past, and we know you will continue to do so.

We thank you for what you have done and for giving us the opportunity to urge your support for continued funding of title VII and its related programs so the future may hold greater options for persons with disabilities.

Thank you, Mr. Chairman.

Mr. MURPHY. Thank you, Mr. DeJong.

[The attachments to James DeJong statement follow:]

ATTACHMENT A

INDEPENDENT LIVING -- A DREAM COME TRUE FOR BETTY AND PEGGY

Just a year ago, Ann Margaret Noble (Peggy) and Elizabeth Umlauf (Betty) were living in a nursing home. They both have cerebral palsy and had experienced more than ten years of institutional living. "There was little freedom of movement, lack of privacy, and 'no say' as far as personal care was concerened," Betty told us.

"We began to look into the idea of living on our own." Peggy then continued, "Neither one of us had any experience, so we started calling different places that offered services to disabled people. After contacting other agencies, we heard about Access Living."

At Access Living, Betty and Peggy, with guidance from the staff, developed a plan to live independently in the community. By utilizing several components of the Access Living services program, they were able to reach their goals.

"They not only helped us find our present apartment, but we received the household management training we needed to maintain our home efficiently," Betty said. "We both feel fortunate that Access Living had enough confidence in us to invest as much time and effort as they did to help us achieve our dream. Now as we celebrate our fifth month of liberation and our first Christmas in our new home, we encourage others to venture into independent living."

Betty and Peggy have taken control of their own destinies. Living on their own has improved the quality of their lives and has saved taxpayers money.. It costs less to provide appropriate support services than it does to pay the bills in a nursing home. Consider the following data which compares Betty and Peggy's nursing home expenses to the cost of independent living.

Cost Data

Yearly Dependent Living Costs
(to taxpayers)

SSI	$ 5280
Medicaid	20440
Hospital	1200
Motorized Wheelchair**	260
2 Manual Wheelchairs ***	400
Total	27580

Yearly Independent Living Costs
(to taxpayers)

SSI*	$ 5280
Personal Care Assistant	9490
[illegible]	—
Medical Supplies and Wheelchair Repair (Paid by Medicaid/Medicare)	600
Rent (Federal Subsidy)	5616
Total	20986

Federal and State Subsidized Funds Saved Per Year Through Independent Living	$ 6594

* Covers utilities, phone, food, transportation, non-subsidized portion of rent and miscellaneous expenses.

** Motorized wheelchair purchase price is $1300 and will be utilized approximately 5 years. Therefore, average cost is $260.

*** 2 Manual wheelchairs purchase price is $1200 and will be utilized approximately 3 years. Therefore, average cost is $400.

ATTACHMENT B

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

JEFFREY C. MILLER
DIRECTOR

316 SOUTH SECOND STREET
SPRINGFIELD, ILLINOIS 62762

January 31, 1983

Mr. James DeJong
Assistant Director
Access Living of Chicago
505 N. LaSalle Street
Chicago, Illinois 60601

Dear Mr. DeJong:

My letter of January 4, 1983, was in error. Per our conversation today I have corrected the statistics.

Non-elderly nursing home residents-either blind or disabled-June 1982 (our most current tabulation for these groups):

State of Illinois

BLIND	DISABLED
69 persons	22,932 persons

Cook County

BLIND	DISABLED
27 persons	9,148 persons

I hope these new figures will assist you in your work and I apologize for any inconvenience the incorrect figures may have caused you.

Sincerely,

Dan Pittman

Dan Pittman
Public Information Office

Mr. MURPHY. Mr. Lex Frieden.

STATEMENT OF LEX FRIEDEN, DIRECTOR, INDEPENDENT LIVING RESEARCH UTILIZATION PROJECT, HOUSTON, TEX.

Mr. FRIEDEN. Mr. Chairman, members of the subcommittee, my name is Lex Frieden. I am director of the independent living research utilization project at the Institute for Rehabilitation and Research in Houston. I am assistant professor of rehabilitation at Baylor College of Medicine and chairman of the Consumer Consultation Committee of the Texas Rehabilitation Commission.

I am speaking today on my own behalf in support of reauthorization of the Rehabilitation Act. The Rehabilitation Act to many of us with disabilities is the single most important piece of legislation affecting our lives. Let me give you some idea from my own personal perspective about how important this particular piece of legislation is.

I broke my neck in an automobile accident in 1967. At that time I had an opportunity to go to one of the few comprehensive medical rehabilitation centers in the country—it happened to be in Houston—and I took part in 90 days of comprehensive medical restoration.

At that point, being confined to a wheelchair and with little use of my arms and hands, there were few options open to me. In fact, the social worker gave me two: I could go and live in a nursing home and they would be able there to provide the kind of assistance that I needed on a day-to-day basis, or perhaps my parents had the resources and the physical abilities to take care of me at home.

At 18 years of age, neither one of those options seemed to be particularly attractive to me, but I took the lesser of two evils and moved back home with my parents.

At that time I had difficulty getting into school because I was disabled. I was turned down by one university because, in fact, I was handicapped. I found a school that, although it wasn't accessible, agreed to make what accommodations it could as I continued to work in the school and finally, in 3 years, graduated from the University of Tulsa.

It was difficult to find a job at that time, in 1972, because people really didn't see the benefits of hiring a person with a disability. In fact, it was difficult for me to prove my value to them as an employee. It was difficult to get back and forth to school, and it would have been difficult to get back and forth to work because there were no public transportation systems in the United States at that time that could provide service to a person in a wheelchair.

There were very few public or private buildings that were accessible to people in wheelchairs. Frankly, there were no systems of community-based personal care available to help me live anywhere besides an institution or my parents' home.

Now, 15 years later, as a result of improvements that have been made by us and as a result of the Rehabilitation Act, particularly the 1973 version of that act, I am able to live in my own home, which I own. I am able to use public transportation to get back and forth to work.

I have worked for Baylor College of Medicine for roughly 6½ years, I have been able to travel all over the United States and many other countries in the world, and I have the benefit of an independent living center in my community which is able to provide assistance to me and personal care activities.

Rather than depending on taxpayers, dollars to support me in an institution, I am able to contribute to the tax base. I think much of this is a result of improvements that we have made in the Rehabilitation Act, so I would like to urge your support of that act.

Title I of the Vocational Rehabilitation Act provides support to State vocational rehabilitation agencies which are teaching people how to get jobs and training those individuals.

Prior to 1973 there was a problem with the act because there was no focus on people with severe disabilities. In 1973 that focus was added to the act. As a result of that, more people who are severely disabled are found eligible for services. But in 1978 we made another significant addition to the act. That was title VII, which provides for independent living services.

Title VII includes four parts, the most important of which are part A, which has not been funded, and part B, which has been funded at a level now of roughly $17.28 million per year. That $17.28 million supports 135 programs funded by the Federal Government. In addition to that, our research in the independent living research utilization project indicates there are roughly 25 additional independent living programs that are not funded by Federal dollars.

The principal services of these programs are peer counseling, peer support and assistance in problem solving with day-to-day activities. The basic characteristics of these programs that make them different from other human service programs, and particularly other rehabilitation programs, is that they are community-based, they depend on the services available in that community, they serve the people in an individual community, and they are basically run by people with disabilities themselves. They provide an excellent model for people who require their services.

It is important to recognize the extent to which these programs are cost effective. I agree with Mr. Spears that the Rehabilitation Services Administration needs to institute an evaluation program so that we have accurate information on the cost effectiveness of these programs, but our research at ILRU seems to indicate that the programs are cost effective. Let me give you one example from the Austin Resource Center for Independent Living.

Last year the ARCIL program helped to place in employment 88 people with severe disabilities. During the year, these individuals paid in taxes $160,160. At the same time, the Government saved $697,728 in funds that before that time had been paid to these individuals in SSI benefits, social security disability insurance benefits, and medicare payments. Altogether that is a total savings to the taxpayer of $857,888.

At the same time, the program that assisted in this employment was receiving a Federal grant totaling $200,000. So you must be aware by now that the programs are, in fact, very cost effective. I would like to be able to have national data to justify the programs to the same degree.

I have a number of recommendations which are included in my written testimony. I hope you will accept that for the record. Among those recommendations is one that relates to a suggestion made by Mr. DeJong, that we do fund part A of title VII of the act.

Part A was intended to provide funds to State governments, State rehabilitation agencies, so that they could purchase services necessary to help severely disabled people reach independent living goals.

Part B was enacted to provide a basis for establishing Centers for Independent Living. I think it has fulfilled its purpose. We now have centers located in every State of the Union. It may be necessary to establish more in the future, so I would recommend maintaining part B at some level, but I think that the funding for these programs now should be delivered through part A so that the States can purchase services from centers as they are needed.

I would also like to suggest that priorities be established within the National Institute for Handicapped Research for independent living as an area of research. I would like to suggest that the Rehabilitation Services Administration establish priorities and technical assistance, using presently available salaries and expenses funds, to provide technical assistance to independent living centers.

I believe we need to establish training priorities in the area of independent living, both within the Rehabilitation Services Administration and the National Institute of Handicapped Research, in order to provide sufficient personnel to staff these centers and to provide training to State agency personnel to better utilize these centers.

Finally, I have one suggestion that I think, perhaps, is significant. I believe our research in the area of independent living during the past 10 years seems to indicate a great savings in human potential and a great savings in the Federal budget could be made by reprograming certain entitlement funds which are now used to foster dependent, institutionalized living by people with disabilities to more progressive, independence-oriented programs of the sort we are discussing here today.

I would propose the appointment of a national commission or study group to investigate and make recommendations for eliminating the many disincentives to independent living by disabled people which are a result of Federal legislation, regulations, and programs.

In particular, this commission should be charged with making recommendations to resolve the apparent inconsistencies between certain institutionalized welfare entitlements and more independence and productivity-oriented rehabilitation programs.

Mr. Chairman, members of the subcommittee, I believe it is possible to help people move out of nursing homes and State-supported institutions, move into the community, to be more productive, and enjoy a better quality of life. I believe it is possible to save money from these entitlement programs, and I believe we should be able to transfer those funds to more progressive rehabilitation and independent living programs.

If you have any questions, I would be more than happy to try and answer them.

Thank you.

Mr. **Murphy**. Thank you very much, Mr. Frieden.

I thank all three members of the panel. Your entire testimonies will be included as part of the record.

[The prepared statement of Lex Frieden follows:]

PREPARED STATEMENT OF LEX FRIEDEN, DIRECTOR, INDEPENDENT LIVING RESEARCH UTILIZATION PROJECT

Members of the Committee and friends:

My name is Lex Frieden. I am director of the Independent Living Research Utilization Project (ILRU) at The Institute for Rehabilitation and Research (TIRR) in Houston, Texas. I am also assistant professor of Rehabilitation at Baylor College of Medicine, and chairman of the Consumer Consultation Committee of the Texas Rehabilitation Commission. I am speaking today on my own behalf in support of reauthorization of the Rehabilitation Act.

To many of us who are disabled, the Rehabilitation Act is the single most important piece of legislation affecting our lives. Title I of this Act provides the basis for a state-federal program of vocational rehabilitation which has helped thousands of disabled citizens, including myself, to acquire education and training necessary for employment. Title II provides for a coordinated program of research under the auspices of the National Institute of Handicapped Research. Title IV authorizes the National Council on the Handicapped, through which we, as consumers and professionals, have an opportunity to influence the policy and direction of the National Institute of Handicapped Research and other programs affecting the lives of people with disabilities. Title V contains Sections 503 and 504 which many of us regard as an affirmation of our equality as citizens. The Architectural and Transportation Barriers Compliance Board, which we value, is also authorized in Title V. Altogether, the Rehabilitation Act must be one of the most comprehensive, best balanced pieces of legislation ever conceived. It is the proven product of years of experience and input by legislators, professionals, and disabled people themselves.

I believe that Title VII of the Rehabilitation Act, better than any other section, epitomizes the progressive, need-oriented nature of this legislation. Title VII authorizes the provision of comprehensive services to support independent living. Although it has not been funded since it became a part of the Rehabilitation Act in 1978, Part A of Title VII establishes the basis of a nationwide program of services to support and encourage independent living and productivity by severely disabled people. Most importantly, Part B of Title VII, in less than five years, has led to the establishment of more than 150 community based, consumer oriented centers for independent living. Research over the past five years by the ILRU project indicates that the most frequent services provided by these centers, and those which distinguish them from other types of rehabilitation and human service programs, are peer counseling, attendant care training and referral, self advocacy training, and assistance in solving problems related to housing, transportation, and employment. The most unique aspect of these programs is that they all involve consumers, people with disabilities, in substantial ways as managers, staff members, board members, and advisors. These programs are uniquely capable of helping people with severe disabilities to reach goals of independence, and to be productive, contributing members of their communities.

Let me give you some idea of the importance and potential of these independent living centers. When I became disabled 15 years ago, my options for leading a comparatively normal lifestyle were quite limited. I had the option of living at home with my parents and depending on them to meet my day-to-day physical needs, or I could live in a nursing home and receive the assistance which I required in an institutional environment. Today, as a result of the progress we have made during the past decade in providing accessible transportation, educational opportunities, affirmitive action mandates, independent living skills training, and other support services provided by independent living centers, I, and many other people with disabilities can lead a comparatively normal, productive life. We can live in our own homes in the community, we can travel, we can work, and we can contribute to improving the quality of life for all people in our communities by being active, responsible, tax paying citizens. Independent living programs have filled a vital gap in the human service continuum.

There are several adjustments and additions to this legislation which I recommend that you consider making in this reauthorization process.

1. In order to establish a basis for purchase of independent living services by state rehabilitation agencies, Part A of Title VII should be funded with such sums as necessary distributed to states which have submitted an approved state plan for providing independent living services.

2. In order to assure that the independent living

program retain those characteristics which make it uniquely effective at facilitating self-reliance by severely disabled people, legislation should require that Title VII, Part B funds should be expended to purchase services only from programs which insure substantial involvement in policy making and operational activities by people with disabilities, and only from programs which provide a broad range of noninstitutionalized services to people with a wide variety of disability types.

3. In order to provide sufficient support for independent living centers funded under Part B of Title VII to become established and stable before federal funds are withdrawn, legislation should specify that all Title VII, Part B grants will be for a period of five years, provided they meet acceptable performance standards.

4. In order to insure fair and objective judgment in determining the assignment of grant funds to independent living centers under Title VII, Part B, sufficient funding and instruction should be provided to the Rehabilitation Services Administration to enable them to employ nonfederal peer reviewers, a majority of whom should be disabled people, to review all new project grants and to assist in evaluating applications for continuations.

5. In order to provide a basis for comparing programs and for determining the effectiveness and cost-benefits of independent living programs, the Rehabilitation Services Administration should be assigned the responsibility for carrying out an ongoing evaluation of federally funded independent living programs and should be given sufficient funding to engage in this activity.

6. In order to provide technical assistance in the development and operation of independent living programs, priorities in the area of independent living should be assigned to technical assistance funds administered by the Rehabilitation Services Administration and sufficient funds should be provided to support this activity.

7. In order to insure continued innovation in programming, priorities related to independent living should be assigned to both research and demonstration project funds and research and training center funds administered by the National Institute of Handicapped Research.

8. In order to insure a sufficient number of qualified individuals to manage and operate independent living programs, priorities related to independent

living should be assigned to training funds administered by both the Rehabilitation Services Administration and the National Institute of Handicapped Research.

Finally, I believe, and our research in the area of independent living during the past ten years seems to indicate, that a great savings in human potential and a great savings in the federal budget could be made by reprogramming certain entitlement funds which are now used to foster dependent, institutionalized living by people with disabilities to more progressive, independence oriented programs of the sort we are discussing here today. I would propose the appointment of a national commission or study group to investigate and make recommendations for eliminating the many disincentives to independent living by disabled people which are a result of federal legislation, regulations, and programs. In particular, this commission should be charged with making recommendations to resolve the apparent inconsistencies between certain institutionalized welfare entitlements and more independence and productivity oriented rehabilitation programs.

I thank you for the opportunity to present this testimony and these recommendations on the Rehabilitation Act. I am convinced that by working together, disabled people, rehabilitation professionals, and members of this subcommittee can insure a sound basis and a firm foundation for future growth of this program which is the most cost-effective, productivity-oriented human service program yet conceived.

Mr. MURPHY. Mr. Bartlett, do you have any questions or comments?

Mr. BARTLETT. Thank you, Mr. Chairman. I have a series of questions.

First of all, I commend the panel for an outstanding presentation. You have packed probably more information into less time than any panel that I have heard since I have been here. You have my commendation.

I have some specific questions. First, taking off on what Mr. Frieden said, which I think is a terribly good idea, it seems to me that what you are suggesting is one of those commonsense things that is probably contrary to every Federal law and every Federal regulation in the book, that is, to permit the vast sums of entitlement programs that are now being expended for simply maintenance, to be used for independent living and as catalysts to allow people to find ways to support themselves and then turn back around and pay taxes.

I wonder if the other panelists would have any comments or suggestions as to how that could be best achieved, or if Mr. Frieden would like to elaborate on that.

Mr. DEJONG. Obviously, representing the independent living programs, I support such a commission. As to the actual process of setting up that commission, I am not quite well versed enough to be able to assist you.

I know that the independent living center operators would view this as tremendous progress, though, and would totally agree that we should move toward helping persons to be on their own and increasing their options for returning to work, rather than just maintaining them within confined environments.

Mr. FRIEDEN. One of the problems we have is that it takes a great deal of resources and energy and personnel, a problem solving capability, in fact, to help people move from an institutionalized setting into the community.

There are no real incentives to help us do that at the present time. I think that if we could prove, for example, that somebody who is now living in an institution, supported with Federal dollars in a nursing home at the cost of roughly $15,000 a year, if we could show some indication that that same individual might be able to live in the community at less cost, then there should be the possibility to transfer the same amount of funds to the center to help provide those services and that assistance in making that move from the institution back into the community, and perhaps eventually to gainful employment.

Mr. SPEARS. Mr. Chairman, Representative Bartlett, I think that NRA would support that concept very strongly. The idea of using the savings as essentially a measure of reinvestment in providing more opportunities and options for independent living is an outstanding one.

Also, the establishment of a study group of some sort could very easily deal with the many technical and very specialized problems that are associated with creating that kind of a reinvestment situation. The idea is an outstanding one.

Mr. BARTLETT. For any of the panelists, what sources of funds are currently available, other than Federal funds, for either the Access

Living Center or other Centers for Independent Living? Are there sources of funds other than Federal funds today?

Mr. **Frieden**. Many of the centers are seeking private funds to help support their programs, through private foundations, through fee for service payment when that is feasible. The fact is, however, that more than 50 percent of the disabled population in this country is now unemployed. Most of those are people who need these services. Consequently, they are not able to pay for the services.

We need to subsidize those services some way, either through grants from the Federal Government, through private foundations, through subsidized fee for service payment mechanisms, or through private contributions. Most of the centers are aggressively pursuing each one of those avenues.

Mr. **DeJong**. I would also agree that there is a difficulty with fee for service directly to the consumer. Our first 800 clients that we saw at Access Living had an average income of $227 per month. Obviously, they were not able to both purchase services and maintain a lifestyle in the community.

Therefore, we do need to look for a purchase of service, possibly through the State rehabilitation agency; 50 percent of our budget is through title VII. The other 50 percent we have gotten through fund raising. The difficulty is to establish services, as I stated.

To be able to establish a program and go out to private foundations all within the same year is virtually impossible. It takes time to establish your credibility in a community. Particularly in a community the size of mine, that is so highly competitive for those private dollars, one must have a very well run program and be able to show the cost effectiveness of that program to the various funding sources.

Mr. **Spears**. In my state we are approaching it slightly differently. Our Minnesota Legislature has shown considerable interest in providing a certain baseline support for our Centers for Independent Living.

We have received in the last two biennial budget periods State funds that are used along with the Federal funds that have been made available to support centers. The State legislature is currently considering a bill that would create a permanent subsidy for the centers in our State.

One of the things we have seen, and I believe it is true in other parts of the country, is that to present funding requests to private funders, you need to demonstrate a minimum level support, so that in essence the private funders are adding on to the funding that is already available through public sources.

Private sources are less inclined to support organizations that don't have a foundation of public support, be it State or Federal, so we in Minnesota are trying a slightly different approach.

Mr. **Bartlett**. Would shifting funding or increasing funding in part A, assist you in obtaining private sources or would it decrease the availability of private sources or State sources?

Mr. **Spears**. It would not substitute for private funds. It would put on a more stable, long-term basis the funding for the centers in the country. Part B is funded on a project basis. Each year a project application has to be written, reviewed and approved. Part A funding, through the administration of the State rehab agencies, can be much more flexible, can be much more simple in terms of delivering the public support to the centers.

I think that both Mr. Frieden and Mr. DeJong would agree that a baseline of public support for the centers is critical, but it will never substitute nor ever fill the entire financial need. There will always be need for private dollars, and the public dollars can and, in fact, are being used right now for the leveraging of private dollars made available to the centers.

Mr. **Bartlett**. Having that stable, long-term source through part A would actually make it easier to raise money, either from State or local governments or from private sources? Is that what you are saying?

Mr. **Spears**. Yes.

Mr. **Bartlett**. So you would have an increased leverage of Federal funds.

Mr. **DeJong**. We might add also, from the center viewpoint, that it would create a cooperative relationship between the centers and the vocational rehab agency within their State that does not exist in every State today.

Many times the centers are viewed as the renegades or the new kids on the block and are not accepted as a service delivery resource and, therefore, I think funding part A would force a cooperative relationship that does make sense.

Mr. **Frieden**. I think it is important not to jump one way or the other, but to begin now to make a transition from that part B dependence for the centers to part A funding. Perhaps this year the appropriations could reflect a movement in that direction, funding both part B and part A, and eventually we may get to the point where we can support the centers entirely through part A.

Mr. **Bartlett**. One last specific question for Mr. Spears.

With regard to Projects with Industry, the statute lists those agencies with whom the commissioner may enter into agreements for the purpose of establishing jointly funded projects.

It is my understanding there is some confusion regarding the status of State vocational rehabilitation agencies and whether the commissioner can enter into agreements with the State.

Do you find that that needs some clarification? If so, how would you clarify it?

Mr. **Spears**. I am not familiar with the nature of the problem. It very well could exist. Projects with Industries, I think, would be enhanced by closer relationships with the State rehab agencies, whatever it would take to accomplish that. I am not familiar with the fine details of the law relative to that program.

Mr. **Bartlett**. So a closer relationship with the State agencies would enhance the partnership with projects with industry.

Mr. **Spears**. Yes.

Mr. **Bartlett**. Thank you, Mr. Chairman.

Mr. **Murphy**. Thank you, Mr. Bartlett.

Mr. Williams?

Mr. **Williams**. Thank you, Mr. Chairman.

Mr. Spears, in your testimony you mention that in Minnesota it has been determined that the return on the public investment in the basic State vocational rehabilitation program is almost 35 percent. I also agree with your ending statement that that is a very impressive return on any investment.

Does your association have any mechanisms in place to measure the relative success of the independent living centers or of other efforts under this legislation?

Mr. **SPEARS**. The Centers for Independent Living?

Mr. **WILLIAMS**. Yes.

Mr. **SPEARS**. NRA is a private organization that does not engage in evaluation, nor do we engage in any very extensive statistical reporting and developing of nationwide statistics. We feel that that really is the responsibility of the Rehabilitation Services Administration.

As I mentioned, I think that the Rehabilitation Services Administration ought to be clearly directed to develop nationwide reporting systems which can then be used as evaluation mechanisms so that you and we together know exactly what our efforts are producing.

Mr. **WILLIAMS**. Later in your testimony you make this statement, that we are coming into an era that has been described as an era of high technology.

What would you recommend we do to bring the benefits of technology and research findings to bear on the problems faced by the disabled, including, of course, the most severely disabled people in our society?

Mr. **SPEARS**. I think that one of the key things is that increased funding be made available for the National Institute for Handicapped Research. It is the design of the act that the National Council on the Handicapped acts as a focusing body for the needs and priorities of research in the area of problems related to people with disabilities.

The statement that I made was designed to call attention to the fact that the increases in technology of all sorts, the standard electronic technology that we think about, bioengineering technology, should be brought to bear on the problems faced by people with disabilities so that the nature of those disabilities and the nature of the handicaps arising from them are less critical in affecting their daily living needs and their employment needs.

Mr. **WILLIAMS**. Thank you, Mr. Chairman.

Mr. **MURPHY**. Thank you, Mr. Williams.

I guess that you leave us with one final wrap-up question. You have all seemed to indicate that the centers have performed their tasks well and that perhaps now we should fund part A.

Do you have a recommendation of any level of funding that we should recommend to the Appropriations Committee for part A? How much would you recommend that we put in part A?

Mr. **DEJONG**. From the national council's viewpoint, Mr. Chairman, we would request to submit that to you at the end of this week. Our national conference is Friday, Saturday, and Sunday and the first item on the agenda is dealing with that exact recommendation to you. So, I am not prepared today to give the viewpoint of the national council, but we will submit that to you by the early part of next week.

Mr. **MURPHY**. Where is your council meeting?

Mr. **DEJONG**. Right here in Washington.

Mr. **Murphy**. We would appreciate that. We are having a continuation of this hearing on Wednesday, and certainly it would be quite timely if we get that next week.

Mr. **DeJong**. We will do so.

[The information referred to follows:]

National Council of Independent Living Programs

RESOLUTIONS

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983 does hereby unanimously recommend funding of Part B, Title VII of the Rehabilitation Act in the following amounts:

1984	$35,000,000
1985	45,000,000
1986	55,000,000
1987	65,000,000
1988	85,000,000

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983, does hereby unanimously recommend funding of Part A, Title VII of the Rehabilitation Act in the following amounts:

1984	$55,000,000
1985	65,000,000
1986	75,000,000
1987	85,000,000
1988	115,000,000

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983, does hereby unanimously recommend amendment of Part B, Title VII of the Rehabilitation Act to provide for grants of 8 years with 5 years of full funding, and descending funding in years 6, 7 and 8 at a rate of 90%, 80% and 70% respectively.

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983, does hereby unanimously recommend amendment of Part A, Title VII of the Rehabilitation Act to provide for a preference in funding under this Part and community based, consumer operated Independent Living Programs, including those funded under Part B, Title VII of the Act.

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983, does hereby unanimously recommend that the Rehabilitation Services Administration establish a priority for providing technical assistance and training to support Independent Living Programs.

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983, does hereby unanimously recommend that the National Institute of Handicapped Research establish a priority for conducting research and training in areas related to Independent Living.

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983, does hereby unanimously recommend that the National Council on Handicapped establish a priority for supporting education and research efforts in the area of Independent Living.

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983 does hereby unanimously recommend that the Rehabilitation Services Administration conduct a comprehensive, on-going evaluation of Part B funded Independent Living Programs, and that this evaluation should be designed and conducted in consultation with the National Council of Independent Living Programs.

BE IT HEREBY RESOLVED, that the National Council of Independent Living Programs assembled in Washington, D. C., Sunday, March 27, 1983 does hereby unanimously recommend that the Rehabilitation Services Administration should employ non-federal peer reviewers, a majority of whom are qualified and knowledgeable persons with disabilities, to review all new applications and continuation proposals for Part B funding, and that criteria for selecting said peer reviewers be designed in consultation with the National Council of Independent Living Programs.

PASSED UNANIMOUSLY

March 27, 1983

Mr. **Bartlett**. If the chairman would yield, I would also comment that if you possibly could, have your council perhaps at least indicate to our staff informally what parameters you are thinking of. Since we are going into markup on Wednesday, the earlier we could get information on your recommendation, even if it is informal, the more useful it would be for this committee.

Mr. Chairman, I would take one moment to commend one member of the panel in particular, as well as the entire panel, and that is Lex Frieden, who has a tremendous reputation in the State of Texas in this area. He has done a tremendous job.

I count him as a friend and as an almost constituent. He lives in Houston, which is 200 miles south of my district——

Mr. **Murphy**. That is pretty close in Texas.

Mr. **Bartlett** [continuing]. And the way the Texas Legislature draws redistricting lines every year, he may well be a constituent before long. I thank him for coming.

Mr. **Frieden**. Thank you.

Mr. Chairman, with your permission I have a number of supporting documents and specific recommendations that I would like to enter into the record, in addition to my written testimony.

Mr. **Murphy**. Thank you. We appreciate having those.

If you have any other specific information between now and full committee markup, it would be appreciated. Even though we are going to mark up in subcommittee on Wednesday, even following that we will be very happy to hear from you.

Thank you very much.

[The information referred to follows:]

ilru information

3-21-83

FOR IMMEDIATE RELEASE

According to a recent research study conducted by the Independent Living Research Utilization (ILRU) project of 147 programs across the country that are providing independent living services to disabled people,

- 104 programs are consumer controlled, with disabled people composing at least 51 percent of the board of directors or 51 percent of the program staff.

- 123 programs provide services to many different disability types rather than focusing on just a single disability type; disability types frequently served at these programs include spinal cord injury, visual impairment, hearing impairment, cerebral palsy, mental illness, stroke, brain injury, deaf-blindness, mental retardation, and others.

- 120 programs provide a comprehensive set of multiple services that enable disabled people to live independently in their communities; typical services include registries of attendants, readers, and interpreters; peer counseling; advocacy; housing assistance; independent living skills training; and other services.

(more)

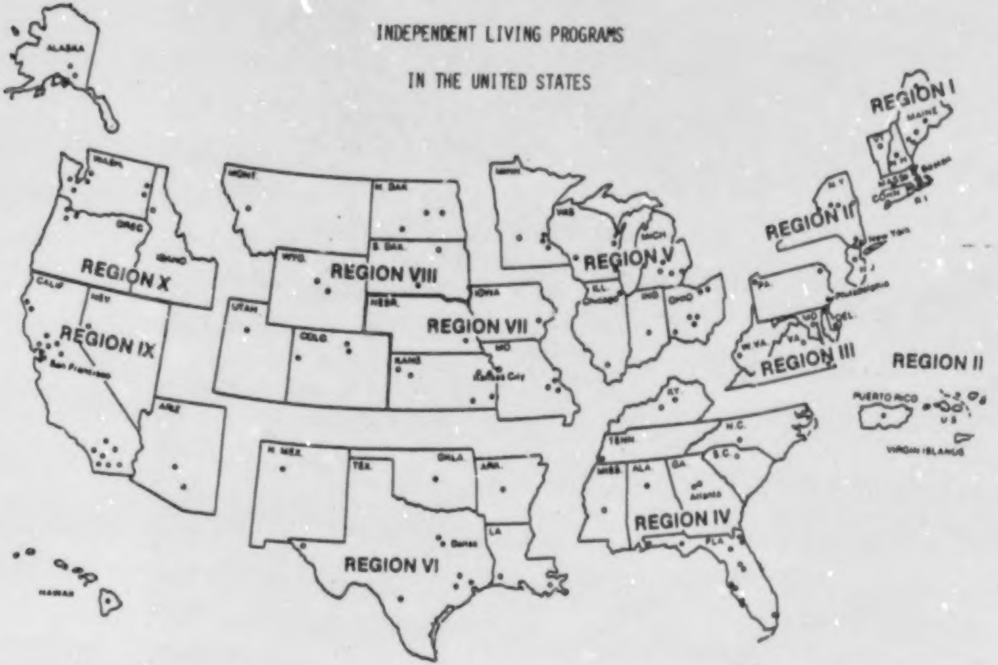
independent living research utilization ■ p.o. box 20095 ■ houston, texas 77225 ■ (713) 797-1440

- 115 programs are non-residential and are able to serve a fairly high number of disabled people annually; for instance, last year, the nation's independent living programs served well over 23,000 disabled people.

For additional information about independent living programs, contact the ILRU project, a national center for information, training, and technical assistance in the field of independent living.

INDEPENDENT LIVING PROGRAMS

IN THE UNITED STATES



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ilru information

INDEPENDENT LIVING RESEARCH UTILIZATION PROJECT (ILRU)

P. O. Box 20095
Houston, Texas 77225
(713) 797-1440 Ext. 504
Lex Frieden, Director

PROJECT OVERVIEW

The ILRU (Independent Living Research Utilization) project is a national center for information, training, and technical assistance for independent living. Its goal is to improve the spread and utilization of results of research programs and demonstration projects in the field of independent living.

Since ILRU was established in 1977, it has developed a variety of strategies for collecting, synthesizing, and disseminating information related to the field of independent living. ILRU project staff serve independent living programs, state rehabilitation agencies, federal and regional rehabilitation agencies, consumer organizations, rehabilitation service providers, educational institutions, medical facilities, and other organizations active in the field, both nationally and internationally.

Initially established by the Rehabilitation Services Administration, ILRU is now sponsored in part by the National Institute of Handicapped Research, U. S. Department of Education. Additional support for the project is provided by grants from both public and private sources and by sales of its products and services.

MAJOR ACCOMPLISHMENTS

- sponsored nine major conferences of national scope, training more than 1,200 persons from all over the country;
- provided on-site technical assistance to independent living programs in 28 states and five foreign countries;
- distributed more than 20,000 books, pamphlets, and videotapes related to independent living;
- developed a comprehensive set of definitions and a method for categorizing models of independent living programs;
- compiled and updated continually a national registry of independent living programs; and
- directed the design of a comprehensive management training program using a simulation format for directors and administrative staff of independent living programs.

MAJOR SERVICES

- producing resource materials related to independent living;
- developing and conducting training programs on independent living issues; and
- providing technical assistance and consultation on independent living.

RESOURCE MATERIALS AVAILABLE

The following items have been produced by the project and are available for distribution. A complete list of ILRU resource materials may be obtained by writing the project.

- *ILRU Source Book: A Technical Assistance Manual for Independent Living*;
- *On the Right Track: Foundations for Operating an Independent Living Program*;
- *Issues in Independent Living: A Technical Report Series*;
- *ILRU Insights*: a national newsletter for independent living;
- *Independent Living: Six Model Programs*--a 60-minute, color, 3/4-inch videocassette;
- *Planning for Independent Living: Using the Individualized Independent Living Plan as a Counseling Tool*--a 17-minute, color, 3/4-inch videocassette;
- *America Needs All Its Citizens*--a poster series depicting severely disabled people in non-stereotypical activities; and
- *A Computerized Registry of Independent Living Programs*.

USER GROUPS

ILRU is open to the public. Project staff will respond to all requests for information related to independent living. Fee schedules and price lists for ILRU services and products are available on request.

6/82

Resource Materials for Independent Living

The ILRU project staff and associates have developed a variety of resource materials related to independent living. These materials include books, handbooks in three-ring notebook binders, monographs, pamphlets, selected reprints, videotapes, and posters.

This brochure is designed to provide information about the products, including brief descriptions, prices, and the procedure for ordering.

In addition to developing resource materials, ILRU staff respond to inquiries related to independent living, preferably by mail.

Publications

Board, Mary Ann, Jean A. Cole, Lex Frieden, & Jane C. Sperry. Independent Living with Attendant Care. 3 Vols. Houston: The Institute for Rehabilitation and Research, 1980.

Vol. 1: "Guide for the Person with a Disability," 20 pages.
Vol. 2: "A Message to Parents of Handicapped Youth," 12 pages.
Vol. 3: "A Guide for the Personal Care Attendant," 24 pages.

Soft-bound books: $3.50 each; $10.50 a set.

Cole, Jean A., Jane C. Sperry, Mary Ann Board, & Lex Frieden. New Options. Houston: The Institute for Rehabilitation and Research, 1979.

The book explores processes through which severely physically disabled individuals become independent members of the community, and examines the New Options project as one model for teaching skills necessary for participating fully in community life.

Soft-bound book, 113 pages: $4.00.

Cole, Jean A., Jane C. Sperry, Mary Ann Board, & Lex Frieden. New Options Training Manual. Houston: The Institute for Rehabilitation and Research, 1979.

The manual deals with specific issues related to operating a program to teach community living skills to severely physically disabled individuals.

Loose-leaf notebook, 129 pages: $6.00.

Frieden, Lex, Laurel Richards, Jean Cole, & David Bailey. *ILRU Source Book: A Technical Assistance Manual on Independent Living.* Houston: The Institute for Rehabilitation and Research, 1979.

The *Source Book* contains detailed information on independent living and is intended to be useful to persons who want to develop independent living programs, to persons who operate independent living programs, and to persons who anticipate using independent living programs as a resource for their clients.

The *Source Book* includes: a glossary related to independent living programs; matrices portraying federal, state, and local resources for independent living; techniques for community organizing; and an annotated bibliography.

Loose-leaf notebook, 90 pages: $20.00.

Issues in Independent Living. Ed. by Laurel Richards. 4 Vols. to date. Houston: ILRU Project, 1980-81.

No. 1: "Independent Living and Deafness: Incorporating Deaf Clients into the Independent Living Network," by Marla Patel, 1980, 29 pages.

No. 2: "How to Set Up an Independent Living Program: Twenty-seven Questions and Answers," by Bruce Curtis, 1980, 16 pages.

No. 3: "Independent Living and Evaluation: Basic Principles for Developing a Useful System," by Timothy Muzzio, 1981, 19 pages.

No. 4: "Independent Living and Mental Retardation: The Role of the Independent Living Program," by Carol Sigelman & Jerry Parham, 1981, 28 pages.

Soft-bound books: $5.00 each.

New Life Options: Independent Living and You, Washington, D.C. & Houston, Tx.: The Institute for Information Studies & ILRU Project, 1979.

This book describes new opportunities available to people with severe disabilities as a result of the passage of the Rehabilitation Act Amendments of 1978. Information is provided about different kinds of independent living programs and sources of technical assistance and financial support available to organizations interested in establishing programs in their communities.

Soft-bound book, 14 pages: $2.00.

REPRINT PACKAGE

A reprint package has been compiled of selected articles written by ILRU project staff which provide a broad-based perspective of developments that have taken place within the inde-

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pendent living field. The reprint package includes the following articles:

Cole, Jean A. "What's New About Independent Living?" Archives of Physical Medicine and Rehabilitation, 60 (10), October 1979, pp. 458-462.

Frieden, Lex. "Independent Living Models." Rehabilitation Literature, 41, No. 7-8 (July-August 1980), pp. 169-173.

Frieden, Lex. "IL: Movement and Programs." American Rehabilitation, 3, No. 6 (July-August 1978), pp. 6-9.

Frieden, Lex & Joyce Frieden. "Independent Living in Sweden and the Netherlands." Mainstream, 7, No. 1 (November 1981), pp. 6-9.

Frieden, Lex & Joyce Frieden. "Organized Consumerism at the Local Level." American Rehabilitation, 5, No. 1 (September-October 1979), pp. 3-6.

Frieden, Lex & Laurel Richards. "Independent Living: Choosing from a Variety of Programs." Disabled USA, 2, No. 9, 1979, pp. 11-14.

"A Glossary for Independent Living." In ILRU Source Book. Houston: The Institute for Rehabilitation and Research, 1979, pp. 1-7.

Widmer, Mary L., Lex Frieden, & Laurel Richards. "Characteristics of Independent Living Programs in the United States." National Spinal Cord Injury Foundation Convention Journal, 1981, pp. 46-51.

Package of 8 reprints,
39 pages: $10.00.
(Reprints not sold separately.)

AUDIO-VISUAL PRODUCTS

Beard, Mary Ann, Laurie Gerken, & Lex Frieden. Planning for Independent Living: Using the Individualized Independent Living Plan as a Counseling Tool. Houston: ILRU Project, 1981.

The videotape depicts a counseling session which might occur at a typical independent living program. Using individualized program planning methodology, the counselor, herself disabled, helps the severely disabled client define her independent living goals and identify specific steps that would lead to achievement of the goals. The videotape is designed to supplement in-service training activities for counselors with independent living case loads.

It received a Certificate of Merit award at the 1981 International Rehabilitation Film Festival.

17-minute, color, 3/4" videocassette: $100.00.

Independent Living: Six Model Programs. Houston: ILRU Project, 1978.

This videotape describes six early independent living programs. It depicts the different approaches each program utilizes in providing or coordinating housing, attendant care, transportation, advocacy, and information/referral services

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to disabled consumers.

The videotape received a Certificate of Merit award from the 1979 International Rehabilitation Film Festival.

62-minute, color, 3/4" videocassette: $100.00.

POSTER

"America Needs All Its Citizens." Houston: ILRU Project, 1981.

Part of an ongoing series, this poster aids in promoting the image of severely disabled individuals making valuable contributions to society. Designed to alter people's perceptions and expectations of persons with disabilities, this poster depicts a man in an electric wheelchair working at a construction site.

Poster, color, 18x24: $5.00.

AVAILABLE FROM CLEARINGHOUSES

The following publications which are out of print may be obtained from the following national clearinghouses: National Clearinghouse of Rehabilitation Training Materials, Oklahoma State Univ., 115 Old U.S.D.A. Bldg., Stillwater, Ok. 74078; National Rehabilitation Information Center (NARIC), Catholic Univ. of America, 4407 Eighth St., N.E., Washington, D.C. 20064; and ERIC Clearinghouse on Handicapped and Gifted Children, 1920 Association Dr., Reston, Va. 22091.

Frieden, Lex, David Sharp, & Tim Finch. CBFL Conference Report 1978. Houston: The Institute for Rehabilitation and Research, 1978.

This report describes a regional training project for handicapped consumer leaders which was sponsored by a Houston-based disabled rights organization. Designed to serve as a primer for similar conferences, this report documents the logistical arrangements involved in planning the conference. It also includes presentations given by keynote speakers, Eunice Fiorito and Frank Bowe.

Soft-bound book, 83 pages.

Stock, David D., & Jean Cole. Cooperative Living. Houston: The Institute for Rehabilitation and Research, 1977.

The report examines Cooperative Living, a cooperative self-support residential system for severely physically disabled young adults. This early independent living program is discussed in terms of its background and purpose as a research and demonstration project, its residents, research methodology and findings, and special considerations which arise when developing living arrangements for persons with severe physical impairments. The epilogue focuses on the individual, following the courses that the forty residents took since the beginning of the project.

Soft-bound book, 132 pages.

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HOW TO ORDER

To order ILRU materials, please fill out and return the enclosed order form or make specific written requests (including item description and price) to:

ILRU Project
P. O. Box 20095
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Prepayment or purchase order form is required. Checks and money orders should be made payable to ILRU PROJECT. Purchase orders are acceptable for orders of $10.00 or more. A 10% discount is allowed on purchases totaling $500.00 or more. Please allow up to six weeks for delivery. Prices are subject to change without notice.

International orders (except Canada) must be accompanied by a $3.00 surcharge to cover costs of international shipping. All payments must be made in U.S. currency.

REFUND POLICY

ILRU guarantees the quality of its products. Postage and handling charges will be deducted from refunds on any materials returned. All requests for refunds must be made within 30 days of receipt of materials.

ABOUT ILRU

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Rehabilitation Services Administration, and it is now sponsored in part by the National Institute of Handicapped Research, U.S. Department of Education. Support for the project is provided by grants from both public and private sources and by sales of products and services.

ILRU PROJECT STAFF

Lex Frieden, Director
Laurel Richards, Training & Materials Development Coordinator
Laurie Gerken, Technical Assistance Coordinator
Mary L. Widmer, Research Analyst
Shirley Herzog, Administrative Secretary

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ILRU RESOURCE MATERIALS - ORDER FORM

ITEM #	TITLE	PRICE	QUANTITY	AMOUNT
	Independent Living With Attendant Care:			
01	A Guide for the Person With a Disability	$3.50	x	= $
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Mr. MURPHY. We now have the second panel this morning, consisting of John Melvin, president, national association of Rehabilitation Facilities, of Milwaukee, Wis.; and Martha Walker, president of the National Council on Rehabilitation Education, from Kent, Ohio, accompanied by Adelle Pietszak, a master of education candidate, rehabilitation counseling, at Kent State University.

I have just been advised that Dr. Melvin missed his plane. Milwaukee must be snowed in. Mr. Cox is here from the national association, if he would care to appear. If he has Dr. Melvin's statement to present, we can accept it into the record and he can answer questions in lieu of Dr. Melvin.

We will proceed first with Ms. Walker.

STATEMENT OF MARTHA WALKER, PRESIDENT, NATIONAL COUNCIL ON REHABILITATION EDUCATION, KENT, OHIO

Ms. WALKER. Mr. Chairman and members of the subcommittee, my name is Martha Lentz Walker, and I am here today representing the National Council on Rehabilitation Education, which is a group of educators, researchers, trainers, and students whose purpose is to improve the quality of rehabilitation services through education and research.

Although the importance of training has been recognized for almost 30 years in the field of rehabilitation, often the necessity for training has been overlooked. It is no easy job to assist a disabled person in making adjustments in living, learning, and working.

It requires someone who is flexible, someone who has a firm, staunch belief in the capacity of the disabled person to live to their fullest potential, and who also believes in this society's commitment to the right to work for every U.S. citizen and their right, also, to live as full a life as they can.

I would like today to introduce to you Adelle Pietszak, who is accompanying me, who is an individual like many who have been recruited through Federal moneys and through efforts of rehabilitation educators to this rather difficult field.

Adelle knows perhaps better than anyone and will be able to describe much more clearly than I the importance of training, not only for a rehabilitation counselor, who is the key person in the rehabilitation process, but also the importance of training for herself as a student.

I would like to ask Adelle at this point to tell you her story.

Mr. MURPHY. Thank you.

Adelle.

STATEMENT OF ADELLE PIETSZAK, M. ED. CANDIDATE, REHABILITATION COUNSELING, KENT STATE UNIVERSITY

Ms. PIETSZAK. Mr. Chairman, members of the subcommittee, I would like to briefly summarize my written statement, if that is all right, for the sake of time.

The Rehabilitation Act of 1973 had a dramatic effect on my life, and I would like to tell you a little bit about that.

As a person who has had a severe disability, muscular dystrophy, since infancy, I received most of my early education at home and in institutions. When I graduated from high school, I applied for rehabilitation services in the State of New York.

That was 22 years ago. At that time, providing services for severely disabled persons wasn't really a priority for the rehabilitation system. I was denied services based on a poor medical prognosis, and also I believe because I was assigned to a counselor who at that time seemed unable to meet my needs.

I struggled for 12 years, living a life that was frustrating and unproductive. I stayed at home most of the time and watched television. I was able to get a few small jobs that I could do at home, but for the most part I really did very little.

I knew I could do more, so I applied for rehabilitation services a second time, and again I was denied. Finally, 12 years later, the third time I applied, I was assigned a qualified rehabilitation counselor who had a master's degree, and with her intervention I was able to get some services on a limited basis.

In 1973, with the advent of the present Rehabilitation Act, my life really changed. Since the act mandated the provision of services for severely disabled persons, I was given assistance so that I could live in my own apartment, hire personal care attendants, and go to college.

In 1980 I received my bachelor's degree in psychology at Kent State University. I am currently working on a master's degree in rehabilitation counseling, and I also teach a sociology course at Kent State. Within a year I hope to receive my certification as a qualified rehabilitation counselor.

Mr. Chairman and members of the subcommittee, I am convinced—no, I know—that without the assistance of that Rehabilitation Act of 1973 and without the intervention of a qualified rehabilitation counselor, I would still be living that unproductive life, probably in a nursing home.

Mr. MURPHY. Thank you very much.

[The prepared statement of Adelle Pietszak follows:]

PREPARED STATEMENT OF ADELLE PIETSZAK, ON BEHALF OF THE NATIONAL COUNCIL ON REHABILITATION EDUCATION

My name is Adelle Pietszak. I am a permanent resident of New York State and am presently studying rehabilitation counseling at Kent State, in Kent, Ohio. I have a unique position in that I have experienced rehabilitation as a consumer and as a student.

Twenty-two years ago, when I was 18, I applied for rehabilitation services after graduation from high school. Although I say "graduation from high school," all my elementary and secondary education took place in my home or an institution. I had been diagnosed as having muscular dystrophy at the age of 18 months and never walked.

In 1960, when I applied for rehabilitation services, severely disabled clients were not a priority for the state-federal VR system. Rehabilitation education was in its infancy, and the counselor who came to my home to interview me left seeming uncomfortable and saying "We'll look over the medical records." He was unprepared for helping me, and I was unprepared to help him, being sheltered and unsure about my vocational possibilities. The result was that I was deemed "ineligible" on the basis of a poor medical prognosis. No vocational evaluation or counseling was provided.

In the five years that followed I had no educational or vocational experiences; I stayed at home and watched TV alot. I felt discontented with my life; I knew I could do more than I was, and I grew tired of waiting.

I discovered a telephone job that could be performed at home. I sought the job and got it, working 22 hours a week for 60¢ an hour. A radio monitoring job supplemented the telephone work, and I earned about $120 per month in that additional employment. Although I was working, and continued to for years, I still felt my capabilities were not being realized. I was living in a dependent setting, and I longed for more independence.

Fastening my interest on psychology, which I had discovered through reading in my spare time, I applied again for rehabilitation assistance to attend a state university to major in Psychology. Again, I was rejected due to my medical records.

My savings from working at home were my remaining option. I enrolled as a part-time student in a community college. After succeeding in the coursework there, I once again contacted the office of Rehabilitation Services, with my academic record in hand. Fortunately, I was reassigned to a qualified counselor.

The visit from my new counselor was very different. She seemed informed, interested, and sensitive to my needs. I was curious about the difference between counselors and asked, "How do you know so much?" She answered that she had a master's degree in Rehabilitation Counseling. As she left, I felt hopeful that I would at last be judged "eligible" for rehabilitation services. And indeed I was.

I was evaluated for vocational potential and for assistive devices that I might need. My further academic training was approved, *and I was given funding on a limited basis.* The *1973* rehabilitation legislation affected my life dramatically, for I was able to hire an attendant and live in my own apartment, attend a university program as a fulltime student, and receive my bachelor's degree in Psychology in 1980.

Today I continue to receive services through the state-federal program, am pursuing a master's degree in Rehabilitation Counseling, and teach a sociology class at the college level. Within a year, I expect to graduate and to begin my career as a certified rehabilitation counselor.

I am convinced that without the assistance of a qualified rehabilitation counselor, I would probably be living with my parents, watching TV most of my day. Training does make a difference; I am daily learning how much there is to know about rehabilitation. I am grateful to have a qualified rehabilitation counselor, and I am equally grateful for the training I am receiving as a graduate student that will adequately prepare me to work with severely disabled persons.

Mrs. **Walker**. Rehabilitation clients who depend upon a qualified person for access to the system and for utilizing that system are many, and Adelle is one representative of that.

The need for persons who are competent and who are committed to this field is greater now than it has ever been, and I would like to say for three reasons.

First, the most recent census figures say that there are 26 million adults in the United States who have a work disability, meaning that their work has been interrupted or discontinued because of disability.

Mr. **Murphy**. What is that figure?

Mrs. **Walker**. The census figure is 26 million for work disabilities.

Rehabilitation counselors are transitional agents, the persons who can get those people back to work. At this time, rehabilitation counseling programs produce approximately 1,500 graduates annually. That means to me that there is a clear need.

Second, the nature of the population served by the rehabilitation program has changed. You have heard this morning I think from several sources that the Rehabilitation Act of 1973, which focused on severely disabled persons, increased the difficulty factor of rehabilitation. Coupled with our economy, which today makes entry into employment even more difficult for a disabled person, these are two severe difficulty factors that show the need for a qualified person.

Finally, we have had damage to this rehabilitation education network in the past 5 years. In 1979 the funding level was such that when we compare it to 1983 in real dollars, rehabilitation training has lost 39 percent of the funding that was then present.

The result of that is that we have a little more than half the numbers of universities providing training programs for rehabilitation counseling funded through Federal dollars than we had in 1979. That is damage to a system that was built over 30 years, and it is severe.

I think that that translates into need for the system and need for qualified personnel, and I would like to suggest that the reauthorization of the Rehabilitation Act of 1973 should reflect our mutual concern about the quality of service and the qualifications of the service provider.

The National Council on Rehabilitation Education would like to suggest one small, but very important amendment to the Rehabilitation Act. We propose that the word "qualified" be inserted before the word "personnel" wherever it appears.

We define the word "qualified" to mean certification and/or licensure by the appropriate State and national certifying body, such as the American Board for Certification in Orthotics and Prosthetics, the American Board of Physical Medicine and Rehabilitation, the American Occupational Therapy Association, and the Commission on Rehabilitation Counselor Certification.

Inclusion of this terminology would provide specific standards for every member of the rehabilitation team, improving all rehabilitation clients' chances of receiving quality services from a broad range of qualified individuals.

Finally, Mr. Chairman, our paramount request is that the Rehabilitation Act be extended for a minimum of 3 years with increased authorizations for the rehabilitation training program. Specifically, we recommend authorizations of $25.5 million in fiscal year 1984, $30.5 million in fiscal year 1985, and $35.5 million in fiscal year 1986.

Thank you for this opportunity to explain the importance of rehabilitation training to the success and effectiveness of the overall rehabilitation program and the need for increased support for this key component in the highly successful Rehabilitation Act.

Mr. MURPHY. Thank you very much, Mrs. Walker.

[The prepared statement of Martha Walker follows:]

PREPARED STATEMENT OF MARTHA WALKER, PRESIDENT, NATIONAL COUNCIL ON REHABILITATION EDUCATION

Mr. Chairman and members of the Subcommittee, my name is Martha Lentz Walker, and I am here today representing the National Council on Rehabilitation Education, an organization of educators, researchers, trainers, and students from more than 80 institutions of higher education whose purpose is to improve rehabilitation services through preparation and continuing education and research.

Thank you for this opportunity to express the position of the National Council on Rehabilitation Education on the reauthorization of the Rehabilitation Act of 1973, and in particular, the value of rehabilitation training.

Although the importance of a qualified professional in the delivery of rehabilitation services has been recognized for nearly thirty years, often the necessity for such personnel has been overlooked. Assisting persons with disabilities in making adjustments to living, learning, and working is no easy job. The rehabilitation process requires flexibility, discretion, and belief in the disabled person's capacity to respond constructively to unwanted change or differences. The process requires the most resourceful providers of service who have been thoroughly prepared for tough going.

Federal training dollars have enabled educators and researchers to recruit capable persons for this difficult field. While no other occupations are more intrinsically rewarding, many do offer higher salaries and less complicated problems. Consequently, shortages of qualified professionals exist in many rehabilitation fields.

I am accompanied today by a student recruited for her promise and partially supported by a traineeship from the Rehabilitation Services Administration. Research has shown that someone with a disability who has received professional preparation, is most likely to be perceived by another disabled person as trustworthy and expert. The importance of training to a client receiving rehabilitation services as well as to a graduate student in rehabilitation counseling is best described by Adelle Pietszak, so I will ask her to tell her story now.

Mr. Chairman, Adelle's "story" is shared by many rehabilitation clients who depend upon the judgment of a qualified professional for access and utilization of the rehabilitation system. The need for competent and committed rehabilitation personnel was first recognized in 1954; today that need is even greater than in earlier years. Let me make several points which reinforce this need.

First, rehabilitation workers are "transition experts" serving the 27 million persons with work disabilities as reported in the 1983 census. When deinstitutionalization efforts are added as markets for "transition experts", the public agencies serving mentally retarded, psychiatrically disabled, offenders, and aging populations could absorb all the graduates of rehabilitation education programs. The parent agency, state vocational rehabilitation agencies, experience annual turnover rates of 14 - 16%.

Attrition alone, in the state agencies, would consume the 1500 graduates currently completing academic programs each calendar year. In other words, we are not able to meet current demands for qualified rehabilitation professionals, and this situation is not likely to improve if we fail to shore up eroding federal support for rehabilitation training.

Second, the need for qualified personnel is greater than ever because of changes in the nature of the population served in the state-federal program, and economic factors. Because of the 1973 Congressional mandate for serving the severely handicapped, the rehabilitation worker has increased responsibilities for serving the severely disabled who are trying to enter an economic system that is less permeable than ever before. These are more difficult rehabilitations which require the attention of well prepared professionals to achieve a successful outcome. Also, limited case service dollars mean that rehabilitation counselors must take on additional functions. For example, they are called upon to perform appraisal and counseling, rather than purchasing these services from psychologists or medical screening teams. These activities require solid training to be accurate and productive.

The need for training to meet new priorities is not limited to those just entering rehabilitation professions. Continuing education is needed to ensure that personnel already in the field also maintain up-to-date techniques and skills, keep up with rapidly changing technology, and can respond to these changing priorities and needs within the rehabilitation program. This is the conduit for insuring that new research results are used in the field. If such training is not provided, then the quality of services will necessarily be lower, and we will be denying the rehabilitation client the best possible outcome. As the April 1980 Rehabilitation Services Administration's Rehabilitation Manpower Plan states, "The ungrading of skills of employed personnel is at all times an important aspect of manpower supply and demand and the shortage of personnel who have been trained to their fullest contributes to any overall rehabilitation "personnel shortage."

Third, damage has been heavy to a carefully developed educational and research system due to the reduction of training funds in the past five years. Since FY 1979, federal support for rehabilitation training has declined from $30.5 million to $19.2 million in FY 1983 -- a loss of 39% in actual dollars, and a staggering decline of roughly 58% when inflation is considered. As a result, today only half as many rehabilitation counselor education programs receive training funds as in 1979. The training funds that are available primarily support students like Adelle in their pursuit of professional training. Authorization levels have been greatly reduced, as well. The 1978 Rehabilitation Amendments authorized funding for rehabilitation training to increase from $34 million in FY 79 to $50 million in FY 82. However, the Reconciliation Act of 1981 reduced that level to only $25.5 million.

These reductions in training have a direct impact on the success of the overall rehabilitation program and the quality of services provided. When research evidence is added to the personal account you have heard today, the effect of a qualified professional is clear. Rehabilitation workers with professional training:

1. have a greater awareness of motivational problems,
2. accept more difficult cases, and
3. achieve successful closure with satisfied clients more frequently than untrained workers, often in a shorter time.

The need for services and qualified personnel is evident; the reauthorization of the Rehabilitation Act of 1973 should reflect our mutual concern about the quality of services rendered and the qualifications of the service provider.

It took much effort on the part of Congress, educators, and researchers to create the educational system that is still in place, despite the severe cutbacks in federal training dollars. Ninety universities located throughout the United States offer rehabilitation specific curriculum. Accreditation standards insure critical instructional components and the learning of essential compentencies, such as:

. developing an evaluation plan and synthesizing information to recommend training or job selection,

. knowing the effects of medical conditions on clients,

- facilitating, client understanding and involvement,
- knowing the job requirements of specific occupations and being able to suggest modifications for disabled workers.

With this in mind, Mr. Chairman, NCRE would suggest one small, but important, amendment to the Rehabilitation Act. We propose that the word "qualified" be inserted before the word "personnel" whenever it appears. We define the word "qualified" to mean certification and/or licensure by the appropriate state and national certifying body, such as the American Board for Certification in Orthotics and Prosthetics, the American Board of Physical Medicine and Rehabilitation, the American Occupational Therapy Association, and the Commission on Rehabilitation Counselor Certification. Inclusion of this terminology would provide specific standards for every member of the rehabilitation team, improving all rehabilitation clients' chances of receiving quality services from a broad range of qualified professionals.

Finally, Mr. Chairman, our paramount request is that the Rehabilitation Act be extended for a minimum of three years with increased authorizations for the Rehabilitation Training program. Specifically, we recommend authorizations of $25.5 million in FY 1984; $30.5 million in FY 1985; and $35.5 million in FY 1986.

Thank you for this opportunity to explain the importance of the Rehabilitation Training program to the success and effectiveness of the overall Rehabilitation Program, and the need for increased support for this key component in the highly successful Rehabilitation Act.

Mr. MURPHY. Mr. Cox, do you have a summary of Dr. Melvin's comments?

STATEMENT OF JAMES A. COX, JR., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. Cox. Thank you, Mr. Chairman.

I am Alan Cox. I am executive director of the National Association of Rehabilitation Facilities.

Dr. Melvin was indeed snowed in in Milwaukee and was not able to be here this morning. Thank you for allowing me to substitute.

The National Association of Rehabilitation Facilities is the primary national organization of community-based vocational and medical rehabilitation facilities. These organizations are vocationally oriented, providing a wide range of services to physically and mentally handicapped persons, including evaluation, testing, skills training, work adjustment training, sheltered employment, and job placement. In addition, many hospitals and rehabilitation centers provide restorative and rehabilitation care to persons who are physically disabled.

The rehabilitation program has always been a cooperative agreement between the Federal Government, the States and the thousands of private, nonprofit facilities providing these services to disabled people.

As much as one-third, Mr. Chairman, of the persons served under this act, and an equal amount of dollars, have been spent annually in these community, nonprofit rehabilitation facilities and hospitals.

These facilities are the basic community source of services for disabled persons and historically have been a catalyst for the development of new and innovative rehabilitation programs.

The Rehabilitation Act was written with that in mind, and the particular section of the act, the innovation and expansion grants section, has been used to stimulate these new and creative approaches to rehabilitation.

Title III of the act authorizes construction and loan programs for facilities. These and other programs, including projects with industry, were intended to act as a stimulus to establish the most effective services.

The President's 1984 budget has proposed that services to severely disabled be increased to 64 percent of individuals served. Most of these individuals will at some time in their service spectrum be served in a community-based rehabilitation facility.

When the act was last amended in 1978, when independent living, community services and several other provisions were added to the act, there were certain features which we had hoped in the succeeding years might be given attention. Specifically, we had hopes that the loan program which was authorized under the act might receive implementation. That has not occurred.

Specific authorization levels were set for the basic State programs in the 1978 amendments, replacing the formula which would have allowed the program to grow with inflation. Many program authorizations were frozen at the level for funding they had received in fiscal year 1981. These programs included research, training and independent living.

The Reconciliation Act specified that certain other programs were not authorized to receive appropriations in fiscal year 1982 or fiscal year 1983. These programs include evaluation, innovation and expansion, facility construction, vocational training services, comprehensive centers, community service employment, and comprehensive independent living services.

We support the reauthorization of the Rehabilitation Act through fiscal year 1986 and would like to bring specific attention to the importance of these special programs within the act.

The board of directors of our association have adopted a position that major changes in the Rehabilitation Act are not warranted at this time. There are, however, several modifications to the act which we feel would strengthen the Rehabilitation Act and enhance services to disabled persons.

If these recommendations are adopted, rehabilitation facilities will continue to provide the services necessary for continued improvement of services to disabled Americans.

Among the specific provisions which we have referenced in our written testimony submitted for the record, and which I would like to highlight this morning, sufficient authorization levels should be set for basic State grants and other parts of the Rehabilitation Act.

Language should be added to make it clear that the authorization for basic State grants is an entitlement and is not subject to reduction by the Appropriations Committee if States are unable to meet the Federal share.

The authorization levels recommended by the Council of State Administrators of Vocational Rehabilitation of $1.037 billion for fiscal year 1984 and the subsequent figures in fiscal year 1985 and fiscal year 1986 are supported by our association as well.

We note with interest that CSAVR, in its statement to the Senate Subcommittee on the Handicapped, stated that a "well funded program of direct services" was essential to the rehabilitation program.

Our board adopted a position last month to support increased appropriations for direct services to disabled persons. Funds appropriated under title I of the Rehabilitation Act for basic State grants should be maximized for direct case services to the greatest extent possible and should not be diminished for nondirect case service functions at the State level. This should be especially emphasized for any funds appropriated above current levels.

Inflation has eroded much of the purchasing power of increases to the rehabilitation basic State grant program over the past several years. Increased costs at the State level have negated the increased allocation from the Federal level. These increased costs, coupled with added costs of working with a more severely disabled population, have resulted in a decrease in the number of persons served and rehabilitated.

We urge the committee to monitor closely the allocation of rehabilitation funds to the States and to limit future increases in funding to direct services to disabled persons.

Further, we feel that 1 percent of the amount appropriated for title I, basic State grants, should be set aside in a discretionary fund for the Commissioner of the Rehabilitation Services Administration, to be used for new and creative approaches to rehabilitation. Such a provision could act as a catalyst for new ideas and provide an alternative for nontraditional approaches.

We feel that the 1-percent amount would be both reasonable and appropriate. We note that the Director of the National Institute of Handicapped Research has a discretionary authority of up to 10 percent.

A significant amount of funds have been returned to the U.S. Treasury each year when funds allocated to States could not be matched or utilized during the year the funds were appropriated.

In fiscal year 1982, over $5.8 million in title I funds were returned to the U.S. Treasury, principally from American Samoa, U.S. trust territories and Puerto Rico, with some lesser amounts from other States.

Section 120, innovation and expansion, we feel should receive a separate appropriation and should be administered on a national level to recognize and encourage more effective programs.

We share the concern expressed for training programs and believe continued emphasis must be placed on the training programs under the Rehabilitation Act. Emphasis should not be diminished on the training of rehabilitation personnel, including facility managers, administrators and allied medical rehabilitation professionals.

As disabled populations become more severely disabled, more extensive and specialized personnel are required to serve their needs. A recent study from the University of Wisconsin-Stout predicts that community facilities will need to double their staff by 1990 to meet the increased need to serve the disabled population.

Programs targeted to rehabilitation facilities in title III of the Rehabilitation Act should be authorized for funding at specified levels for documented needs. Section 301, construction of facilities, and 303, loan guarantees, are especially needed to allow facilities to develop the physical plants and equipment needed to compete in more sophisticated markets, and to train handicapped persons in marketable skills. The reauthorization should direct RSA to implement the loan guarantee program authorized under the 1978 amendments.

Projects with industry should be given a separate title within the act and be authorized at a $25 million level. PWI is not a single program model but a concept that placement into competitive jobs should be the goal of vocational rehabilitation and that the business community should have a strong role in the rehabilitation process.

The development of rehabilitation programs over the years has placed much needed emphasis on the identification of handicapping conditions and the evaluation of a handicapped person's capabilities.

Much progress has also been made in adapting training programs and special equipment to the needs of handicapped persons. For many years, however, efforts to get these handicapped persons into jobs did not receive the same emphasis that evaluation and training received. Projects with industry emphasizes closure of the rehabilitation process.

PWI has demonstrated that with concerted efforts severely disabled persons can be placed into competitive jobs much more quickly and at lower costs than had previously been experienced. The key to the projects with industry concept has been the involvement of the business community in the rehabilitation process.

Nationally, PWI programs have placed over 50,000 disabled persons into competitive jobs. The average salary paid to the PWI graduates has been over $9,000 per year. Seventy-five percent of the disabled persons enrolled in PWI were in fact placed.

The cost to the Federal Government has been less than $1,000 per placement. The Federal funds were supplemented by other State and local funds, including vocational rehabilitation funds. Over 11,000 businesses have participated in the PWI program. The program has proven its worth over 10 years by placing a higher percentage of handicapped persons into private sector jobs at a lower cost to the Federal Government than any other job training or placement program.

A community service employment pilot program was added to the act in 1978. Patterned after the Older Americans Act, it would have promoted useful employment opportunities in public and nonprofit agencies providing community services.

In these times of high unemployment, handicapped persons have a particularly difficult time finding employment. The reauthorization should direct implementation of this program, which has gone unaddressed since being added to the act in the 1978 amendments.

Research regarding the development and improvement of rehabilitative treatment methods and rehabilitation engineering methods and devices is critical to an effective rehabilitation service system. The National Institute of Handicapped Research is under new leadership, and its programs are being administered well. The problem we now face is essentially one of inadequate financial resources.

In this fiscal year, only 50 percent of the applications recommended for funding were funded. Major funding increases are needed in fiscal year 1984 and future years to support meritorious applications and to initiate and expand new programs in research training and small investigator-initiated grants.

Mr. Chairman, these are just some of the recommendations NARF would like to make as this committee considers reauthorization. A more comprehensive statement detailing our review has been submitted to staff for the record.

We would like to commend you, and particularly the staff, for the outstanding job which this committee has performed. We stand ready to continue to work with your staff and with your committee toward an early reauthorization of the act.

Thank you.

[The prepared statement of Dr. Melvin follows:]

PREPARED STATEMENT OF DR. MELVIN, NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

NARF is the primary national membership organization of community-based vocational and medical rehabilitation facilities. Over 350 of these organizations are vocationally-oriented, providing a wide range of services to both physically and mentally handicapped persons. These services include evaluation and testing, skills training, work adjustment training, sheltered employment and job placement. One hundred and fifty of NARF's members are medical facilities offering restorative and rehabilitation services.

The Rehabilitation Act of 1973, as amended, has for many years provided the foundation for the provision of services to mentally and physically disabled persons. The modern federal rehabilitation program has its roots back to the 1920s and has served as a clear indication of the federal government's responsibility and commitment to provide meaningful programs for America's disabled citizens.

The vocational rehabilitation program has always been a cooperative arrangement between the federal government, the states and the thousands of prvate, non-profit community facilities providing services to disabled persons. NARF is proud to represent the private, non-profit sector of the rehabilitation community.

Rehabilitation facilities are the basic community source of services for disabled persons. Historically they have been the catalyst for the development of new and innovative rehabilitation programs. The Rehabilitation Act was written with that in mind. The Innovation and Expansion Grant section of the Act was to be used to stimulate these new and creative approaches to rehabilitation. Title III of the Act authorized construction and loan guarantees for facilities. These and other programs, including Projects With Industry, were intended to act as a stimulus to establishing the most effective services. The President's 1984 budget proposed that services to the severely disabled be increased to 64% of individuals served. Most of those individuals will be served in community-based rehabilitation facilities.

The Rehabilitation Act of 1973, as amended, is up for reauthorization in 1983. The Rehabilitation Act was last amended in 1978 when Independent Living, community services and several other provisions were added to the Act. The Omnibus Reconciliation Act of 1981 extended authorization of the Act through fiscal year 1983. Specific authorization levels were set for the basic state grants at that time, replacing a formula which would have allowed the program to grow with inflation. Many programs' authorizations were frozen at the level they received funding for in fiscal year 1981. These programs included research, training and independent living. The Reconciliation Act specified that certain other programs were not authorized to receive appropriations in fiscal years 1982 or 1983. These programs include evaluation, innovation and expansion, facility construction, vocational training services, comprehensive centers, community service employment and comprehensive independent living services.

It has been five years since any changes have been made in the Rehabilitation Act. The NARF Board of Directors adopted a position that major changes in the Rehabilitation Act are not warranted at this time. There are, however, several modifications to the Act that NARF feels would strengthen the Rehabilitation Act and enhance services to disabled persons. If these recommendations are adopted, rehabilitation facilities can continue to provide the services necessary for the continued improvement of services to disabled Americans. NARF supports reauthorization of the Rehabilitation Act through fiscal year 1986

1. Sufficient authorization levels should be set for basic state grants and other parts of the Rehabilitation Act. Language should be added to make it clear that the authorization level for basic state grants is an entitlement and is not subject to reduction by the appropriations committee if states are able to match the federal share.

   The authorization levels recommended by CSAVR of $1037.1 million for fiscal year 1984, $1141.1 million for fiscal year 1985 and $1254.8 million for fiscal year 1986 are supported by NARF. We noted with interest that CSAVR, in its statement to the Senate Subcommittee on the Handicapped, said that a "well funded program of direct services..." was essential to the rehabilitation program.

   The NARF Board adopted a position last month to support increased appropriations for direct services to disabled persons. Funds appropriated under Title I of the Rehabilitation Act of 1973 for basic state grants should be maximized for direct case services to the greatest extent possible and should not be diminished for non-direct case service functions. This should be especially emphasized for funds appropriated above current funding levels.

Inflation has erroded much of the purchasing power of increases to the rehabilitation basic state grant program over the past several years. Increased costs at the state level have negated the increased allocation from the federal level. These increased costs, coupled with the added costs of working with a more severely disabled population, have resulted in a decrease in the numbers of people served and rehabilitated. NARF urges this Committee to monitor closely the allocation of rehabilitation funds to the states and to limit future increases in funding to direct services to disabled persons.

2. One percent of the amount appropriated for Title I, Basic State Grants, should be set aside in a discretionary fund for the Commissioner of RSA to be used for new and creative approaches to rehabilitation. Such a provision could act as a catalyst for new ideas and provide an alternative for non-traditional approaches. NARF thinks that the one percent amount would be both reasonable and appropriate. The Director of the National Institute for Handi-

capped Research has complete discretion with 10 percent of the funds available to NIHR each year. Ninety-one percent of the total dollars appropriated to the Rehabilitation Services Administration in fiscal year 1982 were passed on directly to the states. Most of the remaining nine percent is part of a categorical discretionary program that gives the RSA Commissioner little, if any, leeway. The discretionary fund could serve as a source of setting national priorities by funding a variety of experimental, demonstration or evaluation projects of national significance. While projects in the states under the Innovation and Expansion Program (Sec. 120) could help implement some of the more creative and innovative approaches, the discretionary fund should be viewed as a more open process to explore new approaches to rehabilitation.

Funding a discretionary program for RSA would not be difficult and would not take money away from states' basic grant programs. Almost every year, rehabilitation funds are returned to the U.S. Treasury because the funds were not expended before the end of the federal fiscal year. Last year, $5.8 million was returned because 11 states and territories had not obligated the funds by September 30. In some instances, these leftover funds were due to differences in state and federal fiscal years. In other cases, anticipated expenditures were not made.

Technical language should be added to the Rehabilitation Act authorizing unexpended federal funds for basic state grants to be carried into the next fiscal year by the Commissioner of RSA to be used to fund projects to further rehabilitation of handicapped persons. Additional funds should be authorized to be appropriated to bring the Commissioner's discretionary fund to no more than one percent of the basic state grant appropriation for that fiscal year.

3. Section 120, Innovation and Expansion, should receive a separate appropriation and should be administered on a national level to recognize and encourage more effective programs.

Innovation and Expansion funding has been alloted to the states on a formula basis to fund the cost of planning, preparing for and initiating special programs to expand vocational rehabilitation services. Special emphasis in the Innovationand Expansion program is placed on serving the most severely disabled and other handicapped populations with special needs. In the past, Innovation and Expansion projects have brought the mentally retarded and cerebral palsied into vocational rehabilitation programs when previously they were thought to be too severely disabled to qualify for rehabilitation services.

Innovation and Expansion projects have not been appropriated separate funds since 1979 when funding for them was combined with basic state grants. In its last year of appropriation, $12 million was allocated to the states for Innovation and Expansion.

Innovation and Expansion funds are one of the few ways the Rehabilitation Services Administration can identify and affect national priorities for the rehabilitation of disabled persons. Under provisions of Section 121, the Commissioner of RSA may require the states to spend 50 percent of the Innovation and Expansion allocation on projects approved by the Commissioner.

The Committee should use this opportunity to place renewed emphasis on the Innovation and Expansion Program and to recommend an appropriation of at least the amount appropriated in fiscal year 1978.

4. Continued emphasis should be placed in training programs. Emphasis should not be diminished on the training of rehabilitation personnel, including facility managers, administrators and allied medical rehabilitation professionals. As disabled populations become more severely disabled, more extensive and specialized personnel are required to serve their needs. A recent study from the University of Wisconsin-Stout predicts that facilities will have to double their staff by 1990 to serve the need.

   Training programs fund projects to help increase the number of personnel trained in providing vocational rehabilitation services to disabled people. Grants are awarded in fields related to vocational rehabilitation of the physically and mentally disabled, such as rehabilitation counseling, rehabilitation medicine, physical and occupational therapy, prosthetic-orthotics, speech pathology and audiology, and rehabilitation of the blind and deaf.

Rehabilitation personnel need more extensive and special training as more and more severely disabled and mentally ill people seek services. Prior to the 1973 and 1978 amendments, many of the people seeking vocational rehabilitation services could be employed and were considered easily rehabilitated, successfully closed cases. The new population seeking services presents different, more complex, longer term problems that place new and different demands on the people helping them. Rehabilitation personnel must be prepared to respond to these changes and require training in new skills.

5. Programs targeted to rehabilitation facilities in Title III of the Rehabilitation Act should be authorized for funding at specified levels for documented needs. Section 301, Construction of Facilities, and Section 303, Loan Guarantees, are especially needed to allow facilities to develop the physical plants and equipment needed to compete in more sophisticated markets and to train handicapped persons in marketable skills.

The reauthorization should direct RSA to implement the loan guarantee program. The loan guarantee program under Section 303 allows the Commissioner of RSA to guarantee the payment of principle and interest on loans made to non-profit rehabilitation facilities for the construction and equipping of such facilities. In addition to guaranteeing the loan, RSA will pay to the holder of the loan amounts sufficient to reduce the interest rate on the loan by 2 percent. There are safeguards in Section 303 to verify the viability of the loans sought to be guaranteed. There are also provisions in Section 303 to minimize the level of appropriation needed to fund the loan guarantee.

Rehabilitation facilities have proven to be good credit risks. The Handicapped Assistance Loan program administered by the Small Business Administration has the lowest default rate of any SBA direct loan program. The Handicapped Assistance Loan program makes loans up to $100,000 to rehabilitation facilities. The loan guarantee provision is needed to make larger loans needed for major capital improvement projects available to rehabilitation facilities at reasonable rates.

6. Projects With Industry should be given a separate title within the Act and authorized at $25 million. Projects With Industry is not a single program model but a concept that placement into competitive jobs should be the goal of vocational rehabilitation and that the business community should have a strong role in the rehabilitation

process. The development of rehabilitation programs over the years has placed much needed emphasis on identification of handicapping conditions and evaluation of a handicapped person's capabilities. Much progress has also been made in adapting training programs and special equipment to the needs of handicapped persons. For many years, however, efforts to get these handicapped persons into jobs did not receive the same emphasis that evaluation and training received. Projects With Industry emphasizes closure of the rehabilitation process.

Projects With Industry has demonstrated that with concentrated efforts severely disabled persons can be placed into competitive jobs much more quickly and at lower costs than had previously been experienced. The key to the Projects With Industry concept has been the involvement of the business community. Among the several Projects With Industry models that have been developed, all have business playing a central role. In some cases, it is the actual business concern that administers the program and places the handicapped trainees. IBM and Control Data have had impressive programs. In other instances, national trade associations have taken the lead such as the National Restaurant Association. Most Projects With Industry programs, however, are administered in local communities by local rehabilitation facilities. Projects With Industry programs at the New Haven Easter Seal-Goodwill Rehabilitation Center is one of the oldest programs and one of the best examples of what such a program can accomplish. In these local programs, a business advisory council helps establish actual job needs in the community, sets standards for training and placement and assists in the actual placement process. The business community brings new measures of success to the rehabilitation process. These measures exemplify productivity, cost effectiveness, accountability and bottom line results. Social service principles and values are still important but they should not be an excuse for poor results.

Nationally, Projects With Industry programs have placed over 50,000 disabled persons in competitive jobs. The average salary paid to these graduates has been over $9,000 per annum. Seventy-five percent of the disabled persons enrolled in Projects With Industry were placed. The cost to the federal government was less than $1,000 per placement. The federal funds were supplemented ~~supplanted~~ by other state and local funds, including vocational rehabilitation funds. Over 11,000 businesses have participated in the Projects With Industry program.

NARF has administered a national Projects With Industry program since 1978. NARF works with five NARF state chapters and 20 rehabilitation facilities to develop programs which use transitional workslots in industry and training based on the recommendations of local employers. Last year, the NARF project placed 493 handicapped persons through a combination of federal, state and local funds. Most of the clients were severely handicapped with the vast majority being diagnosed as mentally ill and developmentally disabled. The salary range for these persons placed was between $6,432 and $19,200.

An independent survey undertaken by Portland State University found that in fiscal 1981 the average hourly range earned by Projects With Industry clients was $4.75. The average cost per placement was $737 in federal funding. In a survey of clients placed through Projects With Industry and other placement programs, it was found that twice as many Projects With Industry clients were likely to be promoted.

NARF believes that the proven success of PWI over the past 15 years clearly justifies expansion of the Projects With Industry concept. Although Projects With Industry has received increased funding over the past several years, it is time that Projects With Industry be given higher visibility. Congress should provide a funding level which will encourage programs in all states and will allow expanded programs in certain industries which hold the most promise for jobs. NARF recommends an authorization level of at least $25 million for fiscal 1984. The current funding level is $8 million and an additional $5 million was added to the fiscal 1983 appropriation for Projects With Industry in the Emergency Jobs

Bill, bringing the fiscal 1983 appropriation to $13 million. The Reagan Administration has recommended $11 million for fiscal 1984. It would take much more than $25 million to meet the needs of handicapped persons who could be placed into competitive jobs. NARF firmly believes that rehabilitation facilities and the business community could meet that need given adequate resources. NARF realizes that an increase of threefold to the appropriations for Projects With Industry would not be easily obtained, therefore this recommendation is for an authorization level of $25 million to emphasis the need to expand Projects With Industry. NARF feels this figure is fully justified given the reduction in public assistance costs and the increased tax revenues that would be realized from the more than 18,000 handicapped persons that could be employed if the full authorization of $25 million was appropriated.

PWI should be given a separate title in the Rehabilitation Act as a concrete indication of Congress' commitment to providing meaningful employment opportunities to handicapped persons. The 1978 amendments also created a grant program for Business Opportunities for Handicapped Individuals in Title VI along with Projects With Industry. NARF recognized the need for providing capital resources and technical assistance to handicapped individuals to enable them to establish and/or operate small businesses. NARF feels that the Handicapped Assistance Loan program at the Small Business Administration best fulfills that role. Therefore Title VI could become the separate title for Projects With Industry.

Projects With Industry should continue as a discretionary national program within the Rehabilitation Services Administration. The flexibility of cooperative agreement between the RSA Commissioner, the private business sector and the private non-profit sector should continue. The flexibility afforded under the current program has allowed and encouraged many businesses to participate in the program when they might not otherwise have been willing to take the initiative to take part in these programs. This flexibility has also allowed local rehabilitation agencies to tailor Projects With Industry programs to meet local needs. If anything, added emphasis should be placed on the cooperative nature of the program between the business community and the local rehabilitation agencies that can assist business in training and placing handicapped persons into meaningful jobs.

7. Section 12 of the Rehabilitation Act states that the Commissioner of Rehabilitation Service Administration may provide "...consultative services and Technical Assistance to public or non-profit, private agencies and organizations." This authority and an earlier provision in Title III were traditionally used to provide technical assistance to rehabilitation facilities in areas such as contract procurement, high technology, cost accounting, marketing,

etc., to help facilities improve their performance in providing services to disabled persons. Technical Assistance, provided under Section 12, allowed facilities to be operated in a more businesslike manner and to become more self-sufficient and less dependent.

In the past, Technical Assistance had been funded at $250,000 per year. Although a small amount when compared to other programs, the appropriation was spread among many facilities since most Technical Assistance provided was of short duration and the amount of money needed for each consultation was relatively small.

The addition of Section 506 of the Act in 1978 caused confusion in the Technical Assistance program since it provided for Technical Assistance to "persons operating rehabilitation facilities" but only for the purpose of removing architectural barriers. Funding was shifted from Section 12 to Section 506 without the realization that this would not allow funding traditional Technical Assistance to rehabilitation facilities.

Two hundred and fifty thousand dollars should be appropriated in fiscal year 1984 for Technical Assistance to rehabilitation facilities under Section 12.

Rehabilitation facilities need access to experts to advise them on issues relevant to providing employment and rehabilitation services to disabled persons. The low cost per consultation and the improvement in services resulting from the consultations make the small appropriations most worthwhile.

8. A Community Service Employment Pilot Program was added to the Act in 1978. Patterned after the Older Americans Act, it would have promoted useful employment opportunities in public and nonprofit agencies providing community services. In these times of high unemployment, handicapped persons have a particularly difficult time finding employment. The reauthorization should direct implementation of this program.

9. Research regarding the development and improvement of rehabilitative treatment methods and rehabilitation engineering methods and devices is critical to an effective rehabilitation service system. The National Institute of Handicapped Research is under new leadership and its programs are being administered well. The problem now is essentially one of inadequate financial resources. In this fiscal year, only 50% of the applications recommended for funding were funded. Major funding increases are needed in fiscal year 1984 and future years to support meritorious applications and to initiate and expand new programs in research training and small investigator-initiated grants.

10. There is a real need for a strong advisory panel to the Commis-

sioner of RSA for rehabilitation services and other programs affecting handicapped persons. The National Council of the Handicapped was formed in 1978 to play both an advisory role and to set policy for Rehabilitation Service Administration and to establish research criteria for the National Insititute for Handicapped Research. Because of the dominant role of politics in the selection of National Council of the Handicapped members and a lack of independent staff, it has not been as effective as it could be as an advisor to Rehabilitation Service Administration and NIHR. The President's Committee on Employment of the Handicapped has been in existence for many years but has never provided the leadership or independence needed to be effective. The National Council of the Handicapped has a budget of less than $200,000 while PCEH has a budget of close to $2 million. A more effective advisory panel might result from consolidating PCEH and the National Council of the Handicapped. The Subcommittee should study the possibility of this merger and hold hearings to determine whether this would be a feasible approach. Legislative changes could be considered after hearings and a thorough study.

11. Section 101 of the Rehabilitation Act should be amended to require that states establish uniform rates of payment systems so that facilities are adequately reimbursed for their services.

There is a direct federal interest in the rates of payment for services utilized by state agencies which relates to cost effectiveness. The Rehabilitation Act of 1973, as amended, both in the state plan requirements and special provisions for facilities in Title III indicates that the Rehabilitation Services Administration and state agencies have responsibilities which transcend the immediate purchase of services for vocational rehabilitation clients. There is a clear mandate to these units of government to insure that the rehabilitation system as a whole, including facilities, be maintained with the capacity to render effective quality service to vocational rehabilitation clients. The ability of facilities and other providers to render services is a function of their ability to cover the cost of rendering of such services. Virtually all support for facilities other than payment for services has been excised from the federal budget. Facility Improvement Grants, Innovation and Expansion funds, and the like are no longer available. Accordingly, if rehabilitation facilities are to retain the capacity to render services both in terms of quantity and quality, it is essential that they both generate revenues from operation at or above their costs.

State agencies cannot fulfill their responsibilities for maintenance of facilities and utilization thereof while eroding the capital base of facilities by paying less than the cost of services rendered. It is suggested that the Act require only payment of the actual cost of services provided. Such a provision would be cost effective, as it will insure that the services capacity of facilities does not deteriorate by virtue of rendering services to clients under the state/federal program. The suggestion that payment for services at rates less than cost is "cost effective" is inconsistent with the maintenance of a sound rehabilitation system. The federal government prescribes methods of payment to providers in such programs as Medicare and Medicaid. The latter is analogous in legal structure and funding to the vocational rehabilitation program as it involves state administration and matching of federal funds for provision of services to designated beneficiaries. Accordingly, there is precedent for such action which is presumably "appropriate."

12. Amend the requirements in the state planning process to require greater public participation. Currently the Act does not require public participation in the preparation of the state plan for rehabilitation services. Specified times and methods of opportunity for public participation are needed to insure that all persons affected by the rehabilitation program may play an active role in the process.

13. Require RSA to have an office, bureau or division devoted to rehabilitation facilities. At least 30 percent of basic state funds are spent in facilities and a much higher percentage of severely handicapped persons are probably served in facilities.

yet only two persons are assigned to the facilities branch in RSA.

NARF urges the Subcommittee to consider the 13 points listed above when they mark-up the bills reauthorizing the Rehabilitation Act of 1973. NARF's staff is willing to offer any assistance requested by Subcommittee members and their staffs that may be of help.

NARF appreciates the hard work this Subcommittee has performed on behalf of disabled persons and looks forward to working with the Subcommittee and staff.

Mr. **Murphy**. Thank you, Mr. Cox.

Mr. Bartlett, do you have any questions?

Mr. **Bartlett**. I do have a few questions.

First, Mrs. Walker, if we were to insert into the act the term "qualified" counselor, as you suggested, I wonder what the immediate effect of that would be. Would you urge us to do that with no phase-in? Would there be counselors throughout the country who would then be unqualified, and thus be laid off? Would those positions then be unfilled? Do you have any idea as to the number of unqualified or nonqualified counselors there are?

Mrs. **Walker**. It varies widely between States, so it is almost a State-by-State number where you would find persons with graduate training, preprofessional training in rehabilitation. NCRE and I would not encourage an immediate action of that sort, but thinking that this is a moment when the State agency has shrunk and personnel is at an all-time low, it is an opportunity to redirect for the future and to assure that those persons who have had the specific training would be hired as those agencies grow. That is why we recommended it at this time. It has never been in the act before this time.

Mr. **Bartlett**. So you would tend to make it applicable to new hires?

Mrs. **Walker**. Yes.

Mr. **Bartlett**. The second question is, can you give us some sense or quantify the number of potential clients that are unserved? You have recommended for training almost a doubling of the budget over a 3-year period. Can you quantify the number of clients that are served now and the number of clients that are left unserved because of budgetary restraints?

Mrs. **Walker**. I am afraid I can't give you a number. I am not prepared to do that now. I think the caseloads have greatly increased in State agencies with the reduction of case service funds and with reduction of staff, but I don't have that information for you. I would be happy to get that to you.

Mr. **Bartlett**. I think what the committee would like to know is, are you suggesting it is not so much a case of clients being unserved but the quality of the service? Is it the case that as the caseload increases per counselor, the quality goes down? People aren't being turned away at the door, are they? I guess that is what I am asking. Are people being turned away at the door because of budgetary constraints or are they just being served less effectively than they would otherwise?

Mrs. **Walker**. As I say, I do not know exactly. I will get that information to you. You understand, from what you are saying, that quality is in a direct reciprocal relationship to the amount of hours that staff has on the State agencies to devote to persons who are coming for services?

Mr. **Bartlett**. Yes.

Mrs. **Walker**. That is correct, and I will try to supply you immediately with that.

Mr. **Bartlett**. Hence my question, and I would appreciate some quantifiable numbers, if you could.

Mr. Cox?

Mr. Cox. Mr. Bartlett, if I may. Our data is largely anecdotal. We lack a national aggregate data base to thoroughly document unmet need, but our experience has led us to believe that as many as three to four times the number of persons being served in facilities are not able to be served because of the lack of available funding through the State agencies who purchase the services or pay for the training slots.

There is a significant unmet need at the community level which the agencies then seek to have met through other funding sources, including charitable donations within the community. We have noticed over the years that a reported unmet need of three to four times the current number being served is being experienced in our community agencies.

Mr. Bartlett. One other question very quickly, and that is with regard to the projects with industry, PWI. Is it your conclusion that State agencies should be permitted to compete for those partnerships and for those grants?

I wonder what information you might have to help determine whether we need a clarification in law to permit State agencies to participate with PWI's. There are some 18 States, I am told, that have applied and been denied because the statute, or at least the administration's interpretation of the statute, doesn't permit it.

Mr. Cox. Where a State agency can show an effective liaison with industry, the private sector partnership that is the intent of the act, I feel that their application should be favorably considered.

The primary problem has been the limited amount of appropriation available for projects with industry and the many good opportunities to form partnerships with industry. There has been great success working hand in hand with specific sectors of industry.

There have been problems where projects have been developed in States and grant applicants have not adequately coordinated with State agencies in the application stage.

I believe this problem has been improved significantly, particularly in the last 2 years, but I would not see any problem with State agencies being considered as an applicant for these funds if the appropriate link with industry had been formed and if it, in fact, was not supplanting other State vocational rehabilitation resources.

Mr. Bartlett. You would not deny State agencies the ability to compete for those private sector grants?

Mr. Cox. That has been the process, a competitive grant process, and there have been far more applications than there have been resources available.

Mr. Bartlett. Thank you.

A very good panel, Mr. Chairman. Thank you.

Mr. Murphy. Thank you, Mr. Bartlett.

To carry that one step further, do you have any specific recommendations on how we can improve the coordination between the State agencies and the placement in Projects with Industry so that it is not just a haphazard placement?

Mr. Cox. Mr. Chairman, you recall the A-76 process in the past has required Federal grant applicants at the State level to coordinate with appropriate agencies within the State.

While these coordination requirements may not be the same today as they have been in recent years, an appropriate requirement for any applicant under PWI would be to notify the State VR agency in the State from which they are applying of their intent; also, there should be inclusion of representatives from State vocational rehabilitation agencies in the panels that review these competitive applications with RSA.

I believe that the coordination liaison, the communication problem, has improved significantly in the last couple of years, but there has been a problem in State agencies not knowing, in fact, if there was a PWI grant application or sometimes until the date of award that it was coming into that State. This should be minimized through better communication liaison between the applicant and the State agencies.

Mr. MURPHY. Do you have any information on what percentage of PWI placements last year were severely disabled?

Mr. COX. No, sir, I do not, but we will certainly look into that and see if we can provide some information to staff on that point.

[The information referred to follows:]

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
P.O. Box 17675, Washington, D.C. 20041 • (703) 556-8848
James A. Cox, Jr., Executive Director

April 11, 1983

The Honorable Austin Murphy
Chairman
Select Education Subcommittee
Education and Labor Committee
U.S. House of Representative
Washington, D.C. 20575

Dear Congressman Murphy:

At the hearing you conducted on March 23, 1983 you asked me a question concerning the number of severely handicapped persons served by Projects With Industry. PWI has been a program which focuses on the end result of the rehabilitation process; the placement of handicapped persons into competative jobs. All handicapped persons placed into jobs under PWI have been clients under the state rehabilitation programs. They may or may not have received services previously from the state rehabilitation agency.

While we do not have precise statistics on the number of severely handicapped persons as opposed to non-severely handicapped person being served by PWI, the enclosed portion of a memo from the Rehabilitation Services Administration indicates that most of the 11,000 disabled persons participating in Projects With Industry in FY 1982 were severely handicapped.

Please let me know if NARF can be of further assistance to you or your staff.

Sincerely,

James A. Cox Jr.

James A. Cox, Jr.
Executive Director

JAC:dsg

Enclosure

7. PROGRAM INFORMATION

The Projects With Industry program is a major private business initiative involving corporations, labor organizations, trade associations, foundations and voluntary agencies which operate through a partnership arrangement with the rehabilitation community to create as well as expand job opportunities for handicapped people in the competitive market. As part of this program, training is provided for jobs in a realistic work setting, generally within a commerical or industrial establishment coupled with supportive services to enhance pre- and post-employment success of handicapped people in the marketplace.

The Advisory Committee established for each project provides the mechanism for members of the private sector to participate in policy-making decisions. This active involvement affords business and industry the opportunity to provide significant input into the design and character of training programs needed to fill essential jobs in the marketplace. Training, therefore, is generally geared to existing job needs. As a direct result more than 75 percent of trainees succeed in being placed in permanent jobs in business.

~~In FY 1982, about 11,000 disabled individuals, most of whom were severely disabled, received services under this program. Seventy-five percent of these individuals, or about [illegible] were placed in jobs in the competitive labor marke~~t. Fifty noncompeting continuation projects and 15 new projects affiliated with more than 2,500 private corporations were funded in FY 1982.

Because all Fiscal Year 1983 funds have been earmarked by the Congress specifically for those projects which were funded in Fiscal Year 1981, there will be no competition for new projects.

8. If additional assistance is needed, contact Walter J. Devins, Division of Special Projects, Rehabilitation Services Administration, Department of Education, 400 Maryland Avenue, S.W., Room 3518, Mary E. Switzer Building, Washington, D.C. 20202, Telephone (202) 245-3189.

Harold F. Shay
Harold F. Shay
Director, Division of Special Projects

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Mr. **MURPHY**. There is one point you made earlier that I don't understand. You had a statement in your testimony that a substantial amount of money is being returned by the States every year when it cannot be matched or utilized during the year. Last year it was $5.8 million, I believe.

Isn't it true that in each fiscal year there is some slippage because we do not coordinate the fiscal year of the States with the Federal fiscal year and that these are not really moneys that are not needed or that could not be matched?

Mr. Cox. No, sir. It is not a question that the appropriations are not needed. They are needed, and increases, in fact, are needed. It is a problem which can be attributed in part to the fiscal year that will differ from State to State from the Federal fiscal year.

Many States begin their fiscal year without any real awareness of what their final appropriations for that year will be. This has led many times to cessation of services in the second or third quarter because of the uncertainty of appropriation or to the dumping of funds into grants in the final days of the last quarter. This is a rather inefficient management system, and it is perpetuated in part by the differences in fiscal years.

The specific request for consideration of the discretionary fund is intended to show that the Commissioner could establish as national policy some direction, some sense of priority if the discretion was available and that it would not necessarily penalize or hurt the States and their basic State allocations in that the approximately $6 million figure, a significant sum of money, is perhaps going unutilized under the current approach.

Mr. **MURPHY**. Would the situation be resolved if we were to actually forward fund to the State governments, something which the act permits but we don't do?

Mr. Cox. That, I believe, has been helpful in the case of some training program grants and also in special education. I am sure the State administrators would welcome the opportunity to comment on that when they testify. That could perhaps alleviate some of the uncertainty which interferes with good management at the State level of the appropriations.

Mr. **MURPHY**. Are there any further questions, Mr. Bartlett?

Mr. **BARTLETT**. No, thank you.

Mr. **MURPHY**. I want to thank the panel very much. We enjoyed hearing you.

Mrs. **WALKER**. Thank you.

Mr. Cox. Thank you, Mr. Chairman.

[Whereupon, at 11:25 a.m. the subcommittee adjourned.]

OVERSIGHT AND REAUTHORIZATION HEARING ON THE REHABILITATION ACT OF 1983

WEDNESDAY, MARCH 23, 1983

House of Representatives,
Committee on Education and Labor
Subcommittee on Select Education,
Washington, D.C.

The subcommittee met, pursuant to call, at 10 a.m., in room 2261, Rayburn House Office Building, Hon. Austin J. Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Simon, Miller, Biaggi, Corrada, Gaydos, Bartlett, Erlenborn, and Coleman.

Staff present: Judith Wagner, majority professional staff member; Patricia Morrissey, minority legislative associate; and Tanya Rahall, majority staff assistant.

Mr. Murphy. Good morning. We apologize for starting a few minutes late. We also will give you an advance apology. We may not be able to conclude the hearing this morning. We may not be able to conclude markup today due to the rescheduling of the budget debate on the floor and, of course, if any member of the subcommittee objects to the continuance of markup, we then must immediately discontinue under the rules of the House.

But we will proceed. We will waive the reading of opening statements, both Congressman Bartlett and myself, in order to expedite the hearing and get to the witnesses we have this morning.

[Opening statement of Chairman Murphy follows:]

Opening Statement of Hon. Austin J. Murphy, a Representative in Congress From the State of Pennsylvania, and Chairman, Subcommittee on Select Education

THIS IS THE SECOND DAY OF OUR REAUTHORIZATION HEARINGS ON THE REHABILITATION ACT. ON MONDAY WE HEARD FROM THOSE IN THE FIELD, ON THE RECEIVING END OF FEDERAL REHABILITATION FUNDS. TODAY WE WILL HEAR FROM THOSE WHO ADMINISTER THE PROGRAMS AT THE STATE AND FEDERAL LEVELS.

CONGRESS HAS NOW RECEIVED TWO ADMINISTRATION PROPOSALS AFFECTING THE FUTURE OF REHABILITATION PROGRAMS. THE FIRST, THE NEW FEDERALISM BLOCK GRANT, WOULD GIVE COMPLETE AUTHORITY TO THE STATES TO USE REHABILITATION FUNDS AS THEY CHOOSE. THE JUSTIFICATION THE ADMINISTRATION GIVES, IN THEIR OWN WORDS, IS "STATES CAN BEST DETERMINE THE REHABILITATION NEEDS OF THEIR OWN CITIZENS AND THE MEANS OF MAKING THEM EMPLOYABLE". SO UNDER THE BLOCK GRANT PROPOSAL STATES COULD CHOOSE TO SERVE ONLY THE SEVERELY DISABLED, OR NONE OF THE SEVERELY DISABLED. OR THEY COULD EVENTUALLY CHOOSE TO TRANSFER ALL OF THEIR REHABILITATION MONEY INTO PROGRAMS FOR NEGLECTED CHILDREN OR FOR LOW INCOME ENERGY ASSISTANCE AND SERVE NO HANDICAPPED PERSONS AT ALL.

THE SECOND ADMINISTRATION PROPOSAL, WHICH WE RECEIVED IN OUR OFFICE JUST YESTERDAY AFTERNOON, SO HAVE NOT FULLY ANALYZED YET, TAKES A DIFFERENT APPROACH. IN THIS PROPOSAL, THE ADMINISTRATION IS SO CONCERNED ABOUT THE STATES' PRESENT SERVICE TO THE SEVERELY DISABLED THAT THEY WOULD RADICALLY ALTER THE METHOD BY WHICH STATES ARE ALLOCATED FUNDS. AGAIN, TO QUOTE THE ADMINISTRATION: "CURRENT LAW SIMPLY DOES NOT PROVIDE ADEQUATE INCENTIVES FOR STATE REHABILITATION AGENCIES AND

PROFESSIONALS."

AT THE SAME TIME, HOWEVER, THIS NEW PROPOSAL ELIMINATES THE SPECIFIC REQUIREMENTS FOR WHAT REHABILITATION SERVICES A STATE MUST PROVIDE WHEN THEY ARE APPROPRIATE.

THE CONTRADICTIONS BETWEEN THESE TWO BILLS, AND WITHIN THE SECOND ONE, LEAVE US PERPLEXED. WHAT DOES THE ADMINISTRATION REALLY WANT TO DO TO A PROGRAM THAT HAS PROVEN ITSELF ONE OF THE MOST SUCCESSFUL SOCIAL PROGRAMS AND ONE OF THE BEST INVESTMENTS THE FEDERAL GOVERNMENT HAS EVER MADE?

BECAUSE OF THE BRIEF TIME AVAILABLE THIS MORNING, AND THE CONFLICTING MARK-UPS SOME OF US HAVE IN OTHER COMMITTEES, WE MAY BE SUBMITTING SOME OF OUR QUESTIONS IN WRITING. BUT WE LOOK FORWARD TO A THOROUGH DISCUSSION OF THE ISSUES, AND APPRECIATE YOUR BEING HERE.

Mr. MURPHY. We're pleased to welcome Mr. Gary Bauer, Deputy Under Secretary of the Office of Planning, Budget, and Evaluation with the Department of Education. Mr. Bauer, you may proceed.

STATEMENT OF GARY BAUER, DEPUTY UNDER SECRETARY, OFFICE OF PLANNING, BUDGET, AND EVALUATION, DEPARTMENT OF EDUCATION

Mr. BAUER. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you.

Mr. BAUER. Let me begin by introducing the other individuals with me this morning. At my left is Mr. George Conn, Commissioner, Rehabilitation Services Administration and Acting Assistant Secretary for Special Education and Rehabilitative Services. Also, at his left, is Wilmer Hunt, Acting Deputy Commissioner, Rehabilitation Services Administration. And to my right is Carol Cichowski, Acting Director, Division of Special Education, Rehabilitation and Research Analysis, Office of Planning, Budget, and Evaluation.

If I may, I will try to go through my statement rather quickly and see if we can have some time for some questions and answers.

I am pleased to present the testimony for the Department of Education on the subject of reauthorization of the Rehabilitation Act of 1973, as amended. The act, as amended, authorizes the allocation of Federal funds on a formula basis to States to provide services to assist disabled individuals to prepare for and engage in gainful occupations. Significant progress has been achieved over six decades to develop a service delivery system in the States to rehabilitate disabled persons.

However, we are proposing amendments to the act as part of our reauthorization effort because we believe there is room for improvement in the rehabilitation outcomes that can be achieved for the severely disabled. For example, about three-quarters of all rehabilitants are placed in the competitive labor market, but for the severely disabled the proportion is only about 65 percent.

In fiscal year 1981 the mean weekly earnings at closure of severely disabled rehabilitants with earnings was $148. For the nonseverely disabled, $168.

Over one-half of the severely disabled rehabilitants received less than the Federal minimum wage in 1981 while 21 percent received no wages at all at case closure. Current law simply does not provide adequate incentives for State rehabilitation agencies and professionals to provide services that produce lasting functional and economic independence at the highest possible levels to the most severely disabled clients.

Regardless of performance, the States receive their funds according to a formula based on population and per capita income. The current measure of success used by the program assigns credit on, we believe, an overly simplistic basis, by combining into a single category employment in the competitive job market and sheltered workshops, unpaid work of homemakers, and unpaid family work.

Several audits and evaluation reports have also indicated that changes are needed in the current rehabilitation system to improve rehabilitation outcomes, especially for the most severely disabled.

In 1976 the General Accounting Office reported to the Senate Subcommittee on the Handicapped that since counselors have traditionally been rated on the basis of the number of persons they rehabilitate and the severely disabled are more costly to rehabilitate, counselors would naturally have some reluctance to allocate a significant portion of their resources to rehabilitating the severely disabled, which would result in rehabilitating a smaller number of clients.

GAO noted that rehabilitation counselors believed that a system which accounted for the cost and difficulty of the cases would give added incentive to increasing services to the severely handicapped, since the emphasis on sheer numbers would be reduced.

There have been several other studies in recent years that make the same points and we will submit those for the record.

We recommend that the Congress consider changes to the Rehabilitation Act of 1973, as amended, that would advance the following principles: Reward States for good performance in rehabilitating the severely disabled; establish a more meaningful measure of program success capable of influencing the talents and energies of State vocational rehabilitation agencies, which will ultimately produce greater functional and economic independence for disabled clients; provide greater State flexibility in the provision of services; and promote stricter accountability to standards in such areas as client eligibility and case closure.

We propose that title I be amended to reward State performance in rehabilitating the severely disabled by distributing part of the funds appropriated for State grants on the basis of a weighted case closure system. Beginning in 1985 one-third of the State grant funds would be allocated to the States on the basis of their performance in rehabilitating the severely disabled.

Rehabilitation would be weighted to maximize the financial incentive for placement in jobs that achieve economic independence. Rehabilitations resulting in employment at or above the Federal minimum wage, which would incorporate statutory or regulatory exceptions for sheltered workshops and work activity centers, would receive a weight of 1.5. Each rehabilitation resulting in employment below the Federal minimum wage would receive a weight of 1.

In recognition of the economic and independence value of unpaid homemaking and family work, these rehabilitations would receive a weight of 0.5.

To insure that employment outcomes are stable as well as financially rewarding, the definition of "successful rehabilitation" would be strengthened to require 120 instead of 60 days of employment. The remaining two-thirds of the appropriations would be allotted to the States using a simplified version of the current formula based on population and per capita income squared.

To provide sufficient time for the States to adjust to the proposed changes in the formula, hold harmless provisions have been included for fiscal years 1985 and 1986.

We're also proposing changes to take effect in fiscal year 1984 designed to provide greater State flexibility in the planning, administration, organization and delivery of rehabilitation services. For example, the amendments retain the requirement for a sole State agency to administer the program, but eliminate the detailed provisions prescribing how that agency is to be organized and administered.

The bill would retain and improve the provisions which provide protections and rights for the handicapped. The bill would retain requirements relating to the priority for providing services to the severely disabled, the individualized written rehabilitation program, the availability of personnel trained to communicate in the client's native language, the prohibition against residency requirements, the review of sheltered workshop closures, and affirmative action for the employment of qualified handicapped individuals.

The bill would revise appeal procedures concerning State review of agency determinations, to include both determinations concerning eligibility of an individual as well as the appropriateness of the rehabilitation services provided.

The bill would also add a provision requiring the State agency to provide client assistance services to all clients and client applicants, including information and advice concerning the benefits available under the act, assistance in pursuing legal, administrative, or other remedies under this act, and appropriate referrals to other State and Federal programs.

In addition, the bill includes a new provision protecting the confidentiality of personal information provided by clients to counselors and agencies.

In order to provide for the continued development of a comprehensive and coordinated program of handicapped research and the dissemination of information on the most effective practices, title II authorizing the conduct of handicapped research through a National Institute of Handicapped Research, is retained under the bill.

A variety of existing discretionary programs are included in title III under a single authorization of appropriation. The purpose of title III is to authorize grants for projects of national or regional significance or projects that meet the unique needs of special handicapped populations.

Although we are not proposing to change the scope or type of activities funded under these authorities, we are proposing some modifications. For example, we are proposing to extend eligibility for grants and contracts under these activities to for-profit organizations. We are also proposing to eliminate specific matching rates and to authorize the use of Federal funds to pay all or part of the cost of projects funded under these programs.

For the longer term it is the administration's goal to reorganize Federal-State delivery of rehabilitation services by returning revenue sources and full program authority to the States. On February 24 the administration transmitted proposed legislation to the Congress that would give States the option of designating a number of programs for turnback during the period of 1984 through 1988.

The vocational rehabilitation program is included in the list of programs that may be designated by participating States because the administration believes the ultimate responsibility for rehabilitating the disabled population can appropriately be assumed by the States.

Rehabilitation services have long been delivered by State agencies. States can best determine the needs of their own citizens and the means of making them employable.

In summary, we believe that the administration's proposal would improve rehabilitation outcomes for the disabled by enhancing both the incentive and the capability of State agencies to make the most effective use of Federal, State, and local resources in serving the disabled. I'd be happy to answer any questions that you may have.

Mr. MURPHY. Thank you very much. Do you have all of your proposals in bill form, the amendments that you have suggested?

Mr. BAUER. Yes; everything has been sent in bill form to the Congress.

Mr. MURPHY. OK, fine. I haven't seen it, but apparently it did arrive late yesterday afternoon.

Mr. BAUER. Yes; I believe it was yesterday.

Mr. MURPHY. I have not had an opportunity to compare it with our bill. We will make an effort to do that before we have full committee markup.

Mr. BAUER. Thank you.

Mr. MURPHY. Mr. Bartlett, do you have any questions?

Mr. BARTLETT. Thank you, Mr. Chairman. I have a number of questions, if the Secretary would help to sort of lead me through some of the answers. Like Mr. Murphy, I hadn't seen the actual bill form and I suppose perhaps as we work down the line on this, it would help us, as Members of Congress, before we get right up to a few days before markup, to have a chance to really sit down and do a section-by-section analysis of the proposal because it's very detailed and I think many of the proposals may be very helpful in terms of providing better rehabilitation services.

Let me first begin, there have been, as I understand it, 18 State agencies that have requested to compete for the projects with industry grants and have been denied because States are not included in the actual statutory language. Can you clarify where that stands and would it require, then, if this committee and if Congress wanted to include State agencies as qualifying for PWI, would that require an amendment in the bill?

Mr. BAUER. I will ask Mr. Conn to address that question.

Mr. CONN. Mr. Congressman, the States are presently permitted to participate in projects with industry programs under section 110 of title I of the Rehabilitation Act. At the State level they have the full flexibility to develop their own PWI programs and many have done so.

The statute does not state that State VR agencies are to be participants in the discretionary PWI program.

It is intended, and I think appropriately so, to address the needs of how to develop rehabilitation capabilities and components within the private sector, and that's what we're trying to do at this time with that discretionary program.

Mr. BARTLETT. So at the present time a State agency is prohibited fron applying for a discretionary program under PWI?

Mr. CONN. Under the statute.

Mr. BARTLETT. Under the statute?

Mr. CONN. On the discretionary side, sir. Under the State grants program, however, they can utilize their own moneys to develop projects with industry with local corporations or with small businesses.

Mr. BARTLETT. Two days ago I suppose we all received a communication from the Vice President on section 504 that the administration contemplates no changes in the regulatory structure of 504 and I wonder if you could confirm that this morning or could you tell us what the status is? Do you anticipate that there will be no regulatory changes in 504 during this session or this year or the next 2 years or for the foreseeable future?

Mr. BAUER. No; we don't anticipate any changes.

Mr. BARTLETT. You have suggested, in your testimony and in the bill, the removing of—and I don't have the page number to refer to—removing of certain minimum services. I wonder if you could elaborate on that somewhat and describe how that would improve the program.

Ms. CICHOWSKI. Currently the statute requires the State agencies to make available a variety of services, including counseling, training, and evaluation. We have eliminated the requirement that the States provide these specific services. This is not to suggest that the States would not, in the exercise of their discretion, choose to provide these services, but we thought it was appropriate to give the States the broadest discretion to put together a service package that they think is most appropriate to achieve rehabilitation outcomes for their clients.

With our emphasis on outcome, we thought the States should have the flexibility to determine what is the best way of meeting that goal and achieving those outcomes for individuals.

Mr. BARTLETT. So it would leave it to the States to set that appropriate level of services as they compete for the grants?

Ms. CICHOWSKI. Yes. Our amendments would put the emphasis of the program on rehabilitation outcomes. We are proposing changes because we've been concerned that the current law does not give enough attention to outcomes. Currently, the definition of rehabilitation does not distinguish between placements in competitive employment and unpaid work. A counselor is given credit for a successful rehabilitation regardless of the type of job the individual is placed in, regardless of the length of employment. If the individual has retained employment for 60 days, the placement is counted as a successful rehabilitation.

What we're proposing to do is to change the statute so that there will be more attention paid to the quality of the outcome that is achieved. In doing so, we think it's appropriate to give the States increased discretion in determining the kind of services they think are most appropriate for achieving those outcomes.

They may opt to put their emphasis in a different place, for example, pay more attention to job placement and training versus physical and medical restoration.

Mr. BARTLETT. Under your reward system or the performance system, let me see if I understand it precisely. You would change the formula, beginning in fiscal year 1985 in a way that would reward States for their performance in terms of number of cases closed? Is that generally the criteria? If so, I would ask if, in your formula, you have given any special weight to assisting severely handicapped as opposed to——

Mr. **Bauer**. Yes; the formula, beginning in 1985, would allocate one-third of the money that the States receive on a competitive basis based on the performance of the State in rehabilitating a weighted number of severely disabled persons.

Mr. **Bartlett**. So it would weight the number of severely disabled?

Mr. **Bauer**. Yes. The whole competition would be based specifically on that category of the disabled.

Mr. **Bartlett**. Would it be prospective competition or retrospective? That is to say, would it be based on the number of rehabilitations that are contemplated in the application or as it happened last year in the State?

Ms. **Cichowski**. The competition would be based on their performance in the prior year.

Mr. **Bartlett**. And that's only one-third of the funds?

Ms. **Cichowski**. Yes.

Mr. **Bartlett**. And you would also include a hoid-harmless agreement so that no State would receive less money than they had on what base year?

Ms. **Cichowski**. We have included hold-harmless provisions for fiscal years 1985 and 1986, the first 2 years of performance-based funding. In fiscal year 1985 a State would receive no less than 90 percent of what it received in fiscal year 1984 and in the following fiscal year, fiscal year 1986, the hold-harmless allotment would be decreased to 75 percent of what each State received in fiscal year 1984. The purpose of the hold harmless provisions is to ease the transition from the current law to performance-based funding.

Mr. **Bartlett**. OK.

Mr. **Conn**. Mr. Bartlett?

Mr. **Bartlett**. Yes, sir, Mr. Conn?

Mr. **Conn**. Some of the thinking that went into this proposal came out of the congressionally mandated White House Conference on Handicapped Individuals between 1975 and 1977. I headed for a while, and was overall director of planning for the economics concern section of that conference. A number of disincentives to employment were identified for handicapped.

The desire to have the independence, self-sufficiency, and the dignity of a job that has been thwarted, to some extent, by these disincentives. That was a major topic of the conference. The materials are available to Members of Congress if they wish to review them, and much of our thinking was based on the results——

Mr. **Bartlett**. Could we get a summary of that?

Mr. **Conn**. Yes.

Mr. **Bartlett**. Of that conference and the result of that and perhaps put it in the record.

Mr. **Conn**. Yes.

There was a report made to Congress made at the termination of the White House Conference, and it should be available to you. We'll see that you get it.

Mr. **Bartlett**. OK.

On the subject of State flexibility, I wonder if you could outline or give examples or quantify in some way those areas in which you think that State agencies don't have sufficient flexibility now. In what ways could State agencies improve their programs if they were given more flexibility?

Mr. CONN. For quite some time the successive commissioners of Rehabilitation Services have met with the Council of State Administrators of Vocational Rehabilitation. The State administrators from time to time have identified what I think is a serious problem, and that is the influence of the Federal Government on the operations of rehabilitation activities at the State level.

We are simply trying to give the States more flexibility and we have found over the years, especially in the past 5 to 10 years, that the amount of dialog and cooperation between constituent groups of disabled people, other professionals in the field of rehabilitation, and the State directors, has increased and improved dramatically and that the States now are ready to do an excellent job of fully administering the programs at their level, with all the flexibility that they need.

We don't feel that the Federal Government has to have as great an interest or presence as it's had in the past.

Mr. BARTLETT. One last factual question, if you know the answer. If not, if you could send it to us. If you could tell us, of the total number of cases that have been placed or closed for each year since 1978, what percentage of those closed cases have been classified as unpaid homemakers?

Ms. CICHOWSKI. The only figure I can recall is for fiscal year 1981. I believe approximately 20 percent of the——

[Audience reacts.]

Mr. BAUER. I detect a note of protest.

Mr. BARTLETT. I think we'd like to have that number, that quantified number. [Laughter.]

Ms. CICHOWSKI. Twenty percent of severely disabled rehabilitations were in unpaid employment. The percentage of cases closed as homemakers is lower than that. But placement in paid work is one of the concerns we have. We think there may be excessive reliance on placement in unpaid jobs which is why, although we're proposing to give some weight to those closures, we're proposing a lesser weight for closures in that type of work to give an increased incentive to placement in paid jobs and competitive employment.

Mr. BARTLETT. So you would have a lesser weight?

Ms. CICHOWSKI. Yes.

Mr. BARTLETT. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you, Mr. Bartlett. We have since been joined on the panel by Mr. Miller of California, and Mr. Conte of Massachusetts. Mr. Conte must return to the floor within a few minutes and would like the opportunity of introducing Mr. Bartels from his home State of Massachusetts. Mr. Conte?

Mr. CONTE. Thank you, Mr. Chairman.

I want to thank you for this opportunity. It seems as though I just left this subject last week, when I had these witnesses before the Appropriations Subcommittee on Health and Human Services and Education.

It gives me great pleasure to present to you today an outstanding professional in the field of vocational rehabilitation. Commissioner Elmer C. Bartels will be testifying before you in a few minutes on the valuable contribution the Rehabilitation Act of 1973 has made to the physically and mentally handicapped persons in the Commonwealth of Massachusetts.

In 1977 Elmer Bartels was appointed by Gov. Michael Dukakis as Commissioner of the Massachusetts Rehabilitation Commission. Since then great advances have been made in providing much-needed services for eligible disabled persons. Through this successful program and through the efforts of Elmer Bartels, handicapped people have been put to work. In fact, I'm pleased to report that this year alone over 4,600 handicapped persons have been placed in suitable positions in Massachusetts. This has reduced their dependency on programs such as supplemental security income and the social security disability insurance, while increasing their own financial independence.

Here is a program which will assist those in need and which, with relatively very little money, will help those people become self sufficient. For every dollar spent on such services, $10 in benefits are generated to offset this expenditure.

This program has proven itself to be cost-effective and invaluable. There can be no argument to refute the need for this program on the basis of its 63-year successful track record. I have committed my support to the Rehabilitation Act of 1973 and I urge you to do the same and to give your full attention to the man who helped contribute so much to making this program the success it is today. May I introduce to you the Commissioner of the Massachusetts Rehabilitation Commission, Elmer C. Bartels. Thank you again for your courtesy and your kindness here this morning. I'll see you at the Appropriations Committee, Commissioner Bartels.

Mr. **Bartels.** Yes.

Mr. **Conte.** I'll be there, Mr. Chairman and Commissioner Conn, when you need me.

Mr. **Murphy.** We're happy to have you in that capacity, Mr. Conte.

Thank you very much, Mr. Conte. We will get to Mr. Bartels' testimony shortly. I do have one or two questions remaining for the administration.

The administration has proposed to apply an incentive mechanism to the distribution of one-third of the amount available for the basic State program. But an incentive provision based on post-rehabilitation earnings might encourage State agencies to select for service those severely handicapped cases which are easiest and cheapest to rehabilitate in order to improve their record. Don't you see the danger of that occurring?

Mr. **Bauer.** Well, I think to some extent there is a danger in the program as it is currently conducted of what may be called creaming. Without any competitive procedure at all in the program, States may, in fact, take limited dollars and apply them to the most easily rehabilitated cases. Something of the same danger may exist to some extent in our proposal, but at least we are trying to guarantee that a significant portion of funds be awarded on the basis of service to the most severely disabled and creaming, to the extent it takes place, would at least take place in that category that most needs the assistance.

Mr. **Murphy**. But you would be encouraging the creaming by your method of reimbursement, rather than encouraging the States to treat every severely handicapped person with equal fervor. They are going to attempt to improve their weighted closures. That's really creaming.

Mr. **Bauer**. Well, by definition, under our proposal, one-third of the money will be awarded on the basis of performance in rehabilitating the severely disabled.

Mr. **Murphy**. Mr. Conn.

Mr. **Conn**. Mr. Chairman, I might point out that the problem of dealing with the easy rehabilitation is one that was addressed by the GAO in the past and in their most recent report. We discussed that with our own staff and we also called in representatives from the Council of State Administrators of Vocational Rehabilitation to see what the situation was so that we could respond to the GAO.

We found that the State directors have made an excellent effort to reduce the amount of so-called creaming going on, to a point where it is almost nonexistent. Our effort here is a sincere one to comply with the recommendations of GAO. Incidentally, we were not asked by the GAO to respond in writing to their recommendations, but we're glad we have the opportunity to do so today in testimony.

Our effort here is a sincere effort to add another incentive to allow the State directors to direct their best efforts toward meeting the needs of severely handicapped people.

Mr. **Murphy**. Your proposal does not say the "most" severely handicapped. It just says the "severely handicapped". You have also just pointed out, another reason why I'm reluctant to change the present language. You have indicated the great success that the State directors have had in not skimming, not taking the cream, not taking the best, that they have reduced "creaming" to a minimum.

Mr. **Conn**. Yes.

Mr. **Murphy**. And I'm afraid that your proposal is going to encourage creaming, as we refer to it.

Mr. **Conn**. Well, we would respectfully disagree, sir. We feel that that's the type of an incentive that could be used very well.

Mr. **Murphy**. It's an incentive to show a better statistics rate and not a better rehabilitation process.

Mr. **Conn**. No, sir.

Ms. **Cichowski**. Mr. Chairman, if I may add to that. The States may have made progress with respect to accepting severely disabled clients and getting them into the caseload and, in fact, closing them as successful rehabilitants.

What we're concerned about is the quality of the case closure. The current program does not address the kind of closure, or the retention of employment.

A State agency gets credit for closing a case as successful regardless of the type of job the individual was placed in, and that's the emphasis we're proposing to put into the program. We believe that credit for a closure should take into account not only the severity of the disability but also the kind of job and the wage level. We think this will better assure that severely disabled individuals are given the maximum opportunity for placement in competitive employment.

Mr. **Murphy**. Well, I laud your goals as you state them but it concerns me. What if we have States with high unemployment rates and they work feverishly and then they are penalized because there's no place to put even non-handicapped workers into meaningful employment?

We would be taking money away from programs that in the long run could be successful but in the short run won't show the statistics to get the dollars for the next year. This again would lead to a greater incentive to skim. I guess we want to accomplish the same purpose, but we don't agree on the paths.

Mr. **Conn**. Mr. Chairman, I went through this process after being injured on active duty with the Air Force in 1957 in the State of Illinois. First at Scott Air Force Base near Representative Simon's area.

We have worked in the past in the State of Illinois as colleagues on this very subject of assisting disabled people, especially those who are severely disabled. With two baccalaureates and a semester of law school following Air Force service, I came out as a paraplegic and it took me 2 years and 175 interviews to get the first job that I had.

Subsequent to that, I have listened to the desires of my fellow disabled people in Illinois, and the States of Washington, Maryland, and Virginia, and I have heard them ask for more help, fewer disincentives, and greater incentives for the opportunity to find a job for which they are qualified, at or above the minimum wage.

We are trying to give the rehabilitation agencies the credit for doing that type of a quality placement, to the best of our ability, and nothing less than that. We feel that's a very laudable goal.

Mr. **Murphy**. Well, I think it is a laudable goal, I really do, and I don't want to nit-pick with you, Mr. Conn. You've gone through it and you know your business better than I, but wouldn't it be far better to provide all the necessary rehabilitation services and not depend on statistics?

You went for 175 interviews. Why should we hold that negative statistic against the State of Illinois so that it would not receive what it needs to conduct a program while you are a negative statistic?

Mr. **Conn**. By improving the placement process, by providing an incentive, by stream-lining, we can reduce that.

Mr. **Murphy**. I just don't know whether a placement process improvement will be accomplished by saying you don't get the money if you don't place them.

Ms. **Cichowski**. Mr. Chairman, regardless of whether Congress chooses to adopt any of the changes we are proposing, there continues to be a considerable interest on the part of both the Congress, our agency, and the State legislatures in the statistics and that's our concern. There has been too much focus on the sheer numbers, numbers of rehabilitations, numbers of closures, and not enough interest in the quality of the closure. That's our point here today, that, unfortunately, counselors are rated and judged on the basis of these numbers by the State legislatures, by the Congress, and that not enough attention is paid to the kinds of jobs the individuals are placed in and whether or not they retain their jobs over time.

Mr. **Murphy**. OK.

Do my colleagues have any questions of the administration?

Mr. **Simon**. Just an observation. As I look at the figures of the numbers who are served, and the total cases served, it appears to me that what we need is not so much incentive as just plain old dollars out there to get the job done.

My instinct, and I particularly respect a man who even knows where southern Illinois is——

Mr. **Simon**. My instinct, my observation, is the people who are working in this field really do not lack motivation. The motivation is there. But we need to give them the tools.

I have no questions other than that, Mr. Chairman.

Mr. **Murphy**. OK.

Yes, Mr. Miller?

Mr. **Miller**. I don't quite understand the statement about the goals you're trying to achieve. The suggestion would seem to be that the people who are involved in this process today are only finding crummy jobs for people. Aren't they trying to find the best paying, the most rewarding, the most career oriented job that they can for clients today?

Mr. **Bauer**. Yes.

Mr. **Miller**. Well, then that's allowable under the law. We don't require crummy job placement? [Laughter.]

I just don't understand the suggestion that somehow your proposal would so dramatically change the goals and allow something to take place that's not allowed to take place today.

Mr. **Conn**. This is not something that we consider frivolous at all.

Mr. **Miller**. It's not a matter of frivolity. It's a matter of whether we embark on an entirely new program.

Mr. **Bauer**. There apparently is a matter of frivolity to the audience.

Mr. **Miller**. Just a second. The matter is whether we evolve an entirely new program to replace that which is already allowed under the law today.

Mr. **Conn**. The rehabilitation field has had a problem with definitions for quite some time, as the program has become more sophisticated, as the law has been broadened, and as more elements have been brought into the act, such as in the Rehabilitation Amendments of 1974 and 1978, the so-called civil rights portion, et cetera.

But to give you an example of what we're concerned about and how we're trying to resolve this, for a long time we depended on a medical model or a medical definition of disability. A person was either minor, moderate, or severely disabled.

On the other hand, we found that the Department of Labor and other committees in the Congress were using another definition which was an occupational definition. The person was either employable or unemployable. The two definitions worked at odds with one another.

The rehabilitation field has worked long and hard to try to blend the two together to try to come up with a functional assessment.

Each time the Rehabilitation Act has been amended we have tried to address the definition of what is a rehabilitation as opposed to what is a placement.

Right now we have a definition of a successful rehabilitation, meaning a placement on the job for 60 days. We simply find that that is an unsatisfactory definition. Both in terms of the service provider and the service recipient. We feel that the challenge must be greater and the incentive greater to insure a better job, that measures up to the capabilities of the individual, a job for which the individual is qualified, and that the person should be employed in that job at least at or above the minimum wage to get the greatest credit for the rehabilitation.

Mr. MILLER. Isn't there some internal inconsistency, and correct me if I'm wrong, that employment for 60 days may be the goal because that may be somewhat difficult to achieve, and yet at the same time the administration, if I am correct, is withdrawing from regulations the availability of postemployment counseling, services for independent living, those kinds of items that would allow, perhaps, individuals to stay on the job or improve their job status after a period of time.

You may increase the success of the 60-day achievement by providing additional services after a person becomes employed.

Ms. CICHOWSKI. Mr. Miller, we haven't proposed any changes in authorized services under the program. I don't know what you're referring to with respect to independent living and postemployment services.

Mr. MILLER. Well, it seems to me that under your block grant that services for independent living, all this gets mixed with a lot of other funding. You have this incentive on placement while postemployment services has become somewhat less of a priority. And I'm just determining what is the mix that this substantial change in the law would provide that is not provided for today?

Ms. CICHOWSKI. If I may comment on postemployment services, our proposed change that would strengthen the definition of successful rehabilitation by increasing the number of days in suitable employment from 60 to 120 that would be required to count a placement as a successful rehabilitation. That should enhance the incentive to provide postemployment services, if those services are required to assist the client in retaining employment.

Mr. MILLER. OK.

Mr. CONN. Mr. Miller, another thing that we are trying very hard to do is to open up the private sector. We are seeing more and more that the private sector has recognized the value of the rehabilitation process and as companies become more involved in this directly they are beginning to build rehabilitation into their own corporate structure.

Through our discretionary programs we hope to continue this process, primarily through projects with industry and other programs.

Eighty-five percent of the jobs that exist in the United States exist in the private sector, either in large corporations or in small businesses. The rehabilitation program is really an evolutionary program. It is the last of the most vulnerable subpopulation groups in the United States to be served in terms of direct governmental services, private sector initiatives, and also civil rights.

Mr. **Miller**. Do those efforts remain mandatory under your provision?

Mr. **Conn**. Yes.

Mr. **Miller**. Within the State block grant?

Mr. **Conn**. Within the State block grant, no. It would give the states greater flexibility.

Mr. **Miller**. Flexibility worries me coming from this administration. [Laughter.]

We ought to withhold the applause and comments from the audience.

Mr. **Murphy**. Yes, the audience should withhold its reactions.

Mr. **Bauer**. Thank you very much.

Mr. **Miller**. Just one final question. On this question of postemployment services, was not that eliminated from State plan requirements under the most recent go-around?

Ms. **Cichowski**. What I was suggesting is that postemployment services continue to be authorized services.

Mr. **Miller**. But previously weren't there required assurances by the States that they would provide professional development training for counselors, and that they would develop postemployment plans?

Ms. **Cichowski**. We have eliminated a State plan requirement that relates to the provision of postemployment services, yes. But the point I was making is that the agencies continue to have the authorization.

Mr. **Miller**. Is the State still required to assure the Federal Government that they're making that effort or is that just one of the things they may choose to do?

Ms. **Cichowski**. No. It would be an authorized service but the States would not have to assure us that they are providing this service. Though again, I would emphasize that they would have an incentive to provide postemployment services to the extent that that would help enable a client to retain employment.

Mr. **Miller**. Well, why are we not requiring them to continue to assure us that that's what they are going to do? Why would you change that in the middle of this operation?

Ms. **Cichowski**. To the extent we've strengthened an incentive to provide those services it wouldn't be necessary to require them to include this item in their State plan.

Mr. **Bauer**. We're trying to focus on outcomes and not procedures, Mr. Miller.

Mr. **Miller**. Do you know how you get to outcomes? You go through procedures.

Mr. **Bauer**. Well, I would assume the people closest to the problem can choose the procedures that best reach the outcomes in their particular State.

Mr. **Miller**. Do you want to relive the Florida experience?

Mr. **Bauer**. Well, no. I just think we have a lot of faith in many of the people in this audience to make the right decisions when attempting to reach appropriate outcomes for their clients.

Mr. CONN. I don't think we'll have to in Florida, Mr. Miller, because the new State director there is a disabled woman and I doubt that will be the case.

Mr. MURPHY. Any further questions, anyone?

OK, we thank the panel very much and welcome your testimony. We will also review the material you sent up to us yesterday before we have full committee markup.

Mr. BAUER. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you.

Our next witnesses are a panel, Norma Krajczar—I may be mispronouncing that name—Elmer Bartels, Vernon Arrell, and Donald Wedewer.

STATEMENT OF A PANEL OF WITNESSES: NORMA KRAJCZAR, DIRECTOR, NEW JERSEY COMMISSION FOR THE BLIND; ELMER BARTELS, DIRECTOR, MASSACHUSETTS REHABILITATION COMMISSION; VERNON ARRELL, COMMISSIONER, TEXAS REHABILITATION COMMISSION; AND DONALD WEDEWER, DIRECTOR, DIVISION OF BLIND SERVICES, FLORIDA

Mr. MURPHY. Norma Krajczar, the director of the New Jersey Commission for the Blind, will be the first witness. Let me add, my colleague from California made the point about the rules of the House. I understand why the audience wants to applaud or boo or whatever, but under the rules of the House that is not permitted.

Ms. Krajczar, am I doing reasonably well on your last name?

Ms. KRAJCZAR. As well as anyone does, Mr. Chairman. Crytz-er.

Mr. MURPHY. Crytz-er. All right.

Ms. KRAJCZAR. Mr. Chairman, in view of the introduction by Congressman Conte of Commissioner Bartels, with your permission I would like to defer the introduction of this panel's comments to Commissioner Bartels.

Mr. MURPHY. Mr. Bartels, we will be pleased to hear from you, the Director of the Massachusetts Rehabilitation Commission.

Mr. BARTELS. Thank you, Mr. Chairman. It's a pleasure to be with you and with members of this honorable subcommittee. I would also like to formally thank Congressman Conte from Massachusetts, who has been so helpful to the rehabilitation program through his membership on the House Appropriations Committee and particularly his leadership in the area of disability with respect to the other programs of this Nation, particularly the social security program.

I think this subcommittee has an outstanding history of supporting the vocational rehabilitation program. I would personally like to thank you for that and also on behalf of the Council of State Administrators of Vocational Rehabilitation.

Our council represents the State directors of every program in this country. We are an organization committed to be supportive of the Rehabilitation Act and to be supportive of disabled people in the United States.

The vocational rehabilitation program, we feel, is a very important one and one that we are all committed to.

We are committed to the vocational rehabilitation program as administrators and in performing the program in a quality way back home, so to speak.

The rehabilitation program, as we have heard this morning, helps handicapped people get to work. Where the rubber hits the road in this program is in the relationship between the counselor and the client at the caseload level. Each counselor has approximately 90 to 100 clients on a caseload and the counselor helps the individual develop a vocational rehabilitation plan which has a vocational objective and defines the services that will help that individual become financially independent through work.

The counselor typically has available "purchase of service" moneys which the counselor would use to buy training, transportation, physical restoration, psychotherapy, and other types of physical restoration that would help to support the vocational plan to enable the individual to become employable in the job market.

We are firmly committed to the belief that skilled handicapped people are employable, and I think we have proved that through the history of statistics in this very important program, and that, in fact, it is very important that people become financially independent through work.

The cost/benefit figures are clear that for every dollar spent there are $10 in benefits returned, plus the reduction in dependency on other Federal programs such as supplemental security income, the social security disability insurance program, AFDC, and general relief at the local level, as well as other support programs such as medicaid, medicare, section 8 subsidies, and other federally funded programs.

In Massachusetts in this past year we served 33,000 handicapped people. We have an active caseload of about 16,000 people and we rehabilitated to work 4,600 handicapped people, 10 percent of these into sheltered employment, which is in fact, from our perspective, a very important closure for severely handicapped people who cannot compete in the competitive job market but who can work effectively and efficiently in a sheltered setting and provide a positive experience for themselves. In fact, out of our sheltered work program each year about 10 percent of the people in the program, move out of sheltered employment into the competitive, working, world.

At this point I would like to ask Norma Krajczar from the New Jersey Blind Agency to give some further background on the program.

Ms. **Krajczar**. Thank you, Elmer.

Mr. Chairman, I am the executive director of the New Jersey Commission for the Blind and Visually Impaired. I am also the secretary-treasurer of the Council of State Administrators of Vocational Rehabilitation, and this morning Mr. Wedewer on my left and I also have the honor of representing the National Council of State Agencies for the Blind, which has its membership among the 50 States who provide specific and unique services for blind and visually impaired persons in their States.

The position which we will be presenting this morning is shared by both organizations and is, we feel, very crucial and important. I would just like to set the stage for the balance of this panel's discussion by reviewing with you the position statement of the Council of State Administrators of Vocational Rehabilitation.

That paper has been provided for your committee. It is not our intention to take your valuable time this morning to read it. But I would like to highlight some of the main points of the position.

It is our contention that this is a most crucial period in time for disabled people. It is a time when the Rehabilitation Act is under review by the Congress for continuation action in some fashion. It is also a period in time when, as we all know, the unemployment rolls have been greatly swelled throughout our country and it is easy to understand that the numbers of disabled people who are unemployed or who must find it extremely difficult to secure employment is disproportionately greater than that of the already-unfortunate population of people seeking work. So the time at which the Congress is being asked to consider the Rehabilitation Act is particularly critical for us.

It's a program which, through 63 years, has proved its value, has a proven track record. It is the result of congressional work on a program and on legislation which perhaps has produced one of the most balanced programs under the Federal system. It's a program which provides direct service to disabled people. It provides the opportunity for innovative programing. It provides opportunity for research and development, for training, for the development of facilities, services, and for cooperative effort with the private sector.

We feel that at this point in time the best course of action for the Congress to take is to support the continuation of this program with appropriate levels of funding, and our position statement represents exactly that point of view. We feel that the program needs three foundations for its success. One is good legislation, and that exists.

The second is appropriate levels of authorization, and as you will note from our position, the bill which is under your review at the moment provides for a level of authorization for a minimum of the next 3 years which will return the purchasing power of that program to the year 1979, which was the strongest year of the program's implementation.

We also believe that the program demands and requires strong Federal leadership and Federal cooperation. It is a program which depends upon State and Federal partnership, and we believe that the Federal partnership has recently been weak and perhaps intends to be weakened.

We feel that that can be very destructive to what is a very good program. If I may speak very briefly about our situation in New Jersey, we are an agency serving blind and visually impaired persons, including persons who are multiply handicapped. And we operate on a very simple philosophy. We know that blindness is generally accepted as a fearful handicapping condition, one which generates a great deal of emotional response on the part of the general public. But we also recognize that it is a handicap which can be dealt with, whose handicapping conditions can be coped with through proper training and proper rehabilitation in such areas as mobility, communications, the learning of braille, and of proper travel.

Obviously, counseling to help one adjust to the condition of his blindness is important. It is a handicapping condition which renders itself to rehabilitation. And with the advent of technology and such devices as, for example, talking calculators, talking computer terminals, braille output on cassette tape, the sky is the limit in terms of employment opportunities and opportunities for gainful activity by blind persons and by severely multiply handicapped blind persons.

I would like to share with you, if I may, two brief case commentaries from our agency which I think represent what vocational rehabilitation is all about. It's about people. It's not about providing service for people. But it's about providing service with people. And in these cases this is exactly what has occurred in our agency.

The first case is of a gentleman, 35 years of age, who is diabetic and whose diabetes is so severe as to require dialysis on a regular basis. His vision, through retinal hemorrhaging, deteriorated and virtually disappeared within a 1-week period of time. He was in a middle management position with the Thomas Lipton Co.

Very fortunately, the company turned to us and said, "This is a valuable employee. We would like to continue him on our rolls. We would like to be able to continue to take advantage of his expertise. Can you help?"

Over a period of time and after analyzing his job on the site, we assisted him, through our rehabilitation center, and through on-the-job continuing training in braille and in mobility to secure and retain that job, and he is now what he was prior to the onset of his blindness, a contributing member of the staff of Thomas Lipton Co. and, I suggest, of his community.

The second case is of a young woman, 34 years of age, with very limited vision and at a point during the pregnancy with her second child, the vision she had failed her and she became totally blind. She was now faced with the task of having to bring up a family with a 2-year-old, and to maintain a household for her working husband. During the period of our training with her in her home, in terms of home management, child management, and again, communications skills, she presented her family with twins.

She is now the mother of three and a housewife maintaining her household. That is a legitimate, viable, very important and very exciting role for her to be playing, and we are proud to have been responsible for the rehabilitation that resulted from our service with this young woman.

I hope that I have set the stage adequately to show you how keenly concerned we are about the rehabilitation program, and with that I will defer my comments back to Commissioner Bartels.

Mr. BARTELS. Thank you, Norma.

One of the other very important programs under the Rehabilitation Act I'd like to talk about just for a moment is title VII, which was added to the program in 1978. That is comprehensive services for independent living.

We have often recognized in the rehabilitation world that there are some individuals who at some point in time are not able to engage in vocational rehabilitation and for whom work is not an objective because their life just hasn't got them to the point of being able to live independently in the community. Title VII authorized a program—a very comprehensive program—of services that included both the service delivery system under what we call part A, a centers project that would develop centers of excellence in independent living under part B, and services for the older blind under part C.

We were fortunate in getting part B funded back in 1979 under the assumption that parts A and C would be funded in following years.

Under the B program we've been able to develop kind of a patchwork of independent living centers around the country that have shown the promise and the ability of these centers, with the direct involvement of many disabled people in the operations of the centers, to help handicapped people to live independently in the community and then look to the vocational rehabilitation program to help them take the next step into the working world.

I think there has been a good deal of demonstration that, in fact, independent living is a good concept and that, in fact, the promise under part A needs to be brought along in order to develop the full flower of independent living rehabilitation.

To give you a couple of examples: In Massachusetts we are maintaining, in this year, 350 handicapped people living independently in the community and also are helping 80 individuals to move into an independent living setting in the community and will be helping to maintain them in the community.

The cost effectiveness of such a program can be thought of in very simple terms in that it can cost up to $30,000 a year to keep an individual in a nursing home or a chronic disease hospital, whereas it can cost $15,000 a year or less to assist a handicapped person to live independently in the community. I think the cost effectiveness figures there are clear.

We are suggesting that the independent living services program under parts A, B, and C, be funded at a $60 million level.

Some other comments in the area of funding, from the Massachusetts perspective again, over the last 5 years we have basically been level funded, when you take into account the Federal funding that we've been able to attract.

Most importantly, under the Social Security Administration changes in 1980 for the reimbursement program, we had our Federal funding cut by 10 percent. That is to say, in fiscal year 1981 we had $2.6 million provided to us by the Social Security Administration to rehabilitate people that were under the SSI or SSDI program.

Under the reimbursement program that went into effect in 1982 we got zero dollars to help rehabilitate handicapped people. Therefore, the program under the Rehabilitation Act of 1973 had to come in and support handicapped people under SSI and SSDI to return to work. That's not to say we should not be providing those services. The point is that the Social Security Administration basically backed out of the program while they got their act together for the reimbursement program. That act still is not together.

Moreover, the effect of inflation has taken its toll on the program. The funding for other community services around the vocational rehabilitation program that we depend upon to help handicapped people to achieve vocational goals has diminished.

We talked about the lack of keeping up with the program in terms of appropriations. Our best year in providing vocational rehabilitation services was in 1977 and in that year we served 41,000 people and helped 6,500 get into the working world. Because of the toll of inflation, the level of funding of the Federal dollar, in this past year we served 32,000 people and rehabilitated 4,600.

I think my point is we have a great capacity to serve. We have shown that in years past. As the Congressman, the chairman, has recognized, our real problem is that of the Federal and State resources, in terms of dollars to do the job.

Many States, in fact, are helping to supplement the Federal dollars over ana above the 20 percent that is required by the program.

But the Federal leadership here is most important—in terms of congressional support for the Rehabilitation Act as it is presently defined and for the Appropriations Committee to follow through with the availability of the Federal dollars—to enable us to, in fact, live up to the capacity and the promise of the program, as we see it.

I would like to ask Don Wedewer of Florida, the Florida Blind Services Division director, to speak on that part of the program.

Mr. WEDEWER. Thank you.

Mr. Chairman, I am Don Wedewer, director of the Florida Division of Blind Services in the Florida Department of Education. It is a pleasure to be here and to testify once more before this subcommittee, which is so sensitive to the needs of the Nation's handicapped. It has been so sensitive that marvelous legislation such as the Rehabilitation Act of 1973, as amended, has been put on the books and allowed us, as administrators, to administer a program that has, indeed, done a great deal of wonderful things to put severely handicapped people back in the mainstream of our society.

I was blinded and lost both my limbs as a result of combat wounds in World War II. I benefited from the Army and Air Force and Veterans' Administration rehabilitation programs, and fortunately, the rest of the handicapped people in this country have a program that has been set up for 63 years to benefit them.

We are very cognizant of the need and the desire of all of us to, particularly, rehabilitate the most severely handicapped. The Rehabilitation Act of 1973, I believe, is one of the finest pieces of legislation that has ever been passed because it addresses that very issue in a very significant way and has permitted us, the State directors, to act on it. In fact, we are doing just that.

I don't think anyone has mentioned the fact that since the act has been passed, that the concentration has been on the severely handicapped. The State directors aren't number conscious. We are not numbering people. I worked as a counselor and as a placement person and a local supervisor and all that before becoming director, as most of us have. We're aware of that problem and the so-called numbers game.

As a matter of fact, we don't like the numbers game at all, and I think that if you read statistics at all about this program you will know that in the last few years the numbers of severely handicapped being rehabilitated has gone up. The percentage has gone up. And that's exactly what we're doing. I don't think we need any more incentive. We've got all the incentive we need.

The only thing we need is probably more money because of the cost of high technology, which is required to rehabilitate our multiply handicapped people.

Now, in the agency I run in Florida, we also serve the preschool blind and the school children who are blind and the elderly, but we keep a very detailed registry. We have registered, in our marvelous State of Florida, 8,500 people, on average, for the last 7 years, a total of 60,000 new people, who are blind and visually handicapped.

Of the 2,000 children we have registered and who are now on the rolls, two-thirds are multiply handicapped. That is not just Florida; it's like that in every State. All the States have neonatal clinics and they're all seeing this happen. It's a challenge to us, but it's also an opportunity to develop these young people into the same citizens that many of us have been developed into through rehabilitation.

That doesn't scare us; I think it doesn't scare you.

We hear that unemployment is great right now and I know the statistics are thrown out that 50 percent of all severely handicapped people are unemployed—in the blind sector, maybe 70 percent—but the truth is we are rehabilitating many, many severely handicapped people into good jobs. In the private sector too, I might add.

Now, just for example, Norma Krajczar mentioned a couple of people. I will mention two examples which are just happening. We had a blind student we started working with in junior high; he went through the University of Florida; he got a degree in electrical engineering last June. His grade point average was 3.9. He's totally blind. He was honored as one of the Nation's outstanding blind students here at the White House in the rose garden last year and immediately was offered two jobs by IBM and General Dynamics and took one with IBM for $25,000.

We worked with him. We bought some expensive equipment for him, a range of computers and speech output equipment, but there he is, a success story. And those success stories are all over the country.

We have another young student at Florida State University who is just finishing a degree in computer science. We already have a State agency he's working with on an experience level that has offered him a job, not as a computer programer but as an analyst with a good salary, and he's about to graduate in June.

These young people are just two examples of what is an everyday occurrence, almost, around the country. Furthermore, we just graduated a class of people trained to work in the electronic industry, which is pretty common in Florida because of NASA, and all of the entire class was hired by a corporation in Fort Lauderdale, the entire class of young blind people, very young people, with their skilled training.

This is all a result of what you have proposed with your legislation, the money you have provided, and what we can do with it when we have it.

The truth is that all of our States are providing enough money to match Federal funds and, as a matter of fact, in my 10 years now, 10th year as a State director, the State of Florida has increased money for rehabilitation every year. It's not ever gone backward.

We don't anticipate it to. We are with you in meeting the needs of our citizens and we're proud that you are doing it and proposing to continue to do it.

None of us overlook the severely handicapped these days because that's really who everyone is serving, as I think we have explained here this morning.

We have been hurt, of course, by cuts in the SSI and SSDI program. We have been hurt because of similar benefit cuts in other categories where we've had to make up for it. We have reduced staff, sometimes cut vacancies. We've done everything in the world to find more dollars for the people we serve, and with high technology it's very expensive.

But the marvelous thing is that with all this high technology, our severely handicapped people can now compete both in the private sector and everywhere, pretty much with everyone else, and that's where the excitement is and, you know, the truth is it's working.

We have plenty of flexibility, I might add. That word bothers me some too, Congressman, and I don't know where it is lacking. We probably can use a little more direction and help from up here in what we do. I'm not familiar with what their proposal is about this incentive business, but the truth is that I'm a competitor and would love to compete. But on the other hand, someone should not be punished because their State is not doing quite as much. The severely handicapped shouldn't be punished anywhere. And there's no more incentive in the world that is needed.

Flexibility, we have plenty of it. In fact, we're hearing mixed signals. That's our problem. We're told by OMB they don't want our statistics. On the other hand, they're telling us that we have statistics to show we're not doing something, or they want us to do something else, and they're even going to give their money out based on those statistics. I don't know where they're going to get their information, unless they start giving us one signal, Congressman, and not a whole group of signals.

So with that I'd like to say I appreciate the opportunity of being back with you again and assure you that Florida is doing well and I invite you down for your Easter holiday.

Mr. MURPHY. I accept. [Laughter.]

Mr. ARRELL. Would you invite the rest of us down too?

Mr. WEDEWER. Yes.

Mr. ARRELL. Thank you.

My name is Max Arrell. I am commissioner of the Texas Rehabilitation Commission in Austin, Tex. We are an independent agency established by our legislature. I work for a board and it's appointed by our Governor. As each of us, I believe, are under separate types of organizations, some under the education agency, some under larger agencies, I think it's very important for everyone to understand that regardless of the type of agency or the type of organization that we have, it's very possible to have a very efficiently run, effective organization in State rehabilitation, which we do have, and will continue to have.

I do appreciate very much and it is sincerely my pleasure to come here today and advocate and speak in favor of the best human service delivery system for the disabled community that's ever been known to this country, the 63-year-old State/Federal vocational rehabilitation program. It's a tried and proven program. It's one that has been unparalleled by any other program in this country. I have been a part of this program for 23 years. I worked as a counselor, an administrator, and now a chief executive officer of a State rehabilitation agency, which, by the way, is the hub of the rehabilitation program and has been and should continue to be.

What makes this all possible for us is a very good piece of legislation called the Rehabilitation Act. It's a tried and proven act. It's probably the most complete and well-balanced legislation in the human services field. It's one that has served us very well, and legislation that serves you well, I feel, is one that you don't abandon and you don't fragment.

Now is the time to extend and enhance and better fund rather than fragment, and I feel that there is that very real possibility with some of the testimonies I've heard here today, of fragmenting a program that has been proven and successful for 63 years.

The thing that we would indicate to you here today and ask your sincere consideration, as my colleagues here on the panel have said, would be to extend the Rehabilitation Act as is, consider funding to a point that it would bring us to the level where we would be back to our 1979 buying power.

I think that the extension of the Rehabilitation Act will again insure stability in our State/Federal program and allow us to continue to provide the comprehensive services that are needed for the severely disabled. The severely disabled of this country, at least in my State and I'm sure it's the same everywhere, have come to realize, understand, and expect good, comprehensive, services from the vocational rehabilitation program. They have received those services, they should continue to receive them, and I think that we should give them nothing less.

I would like to take just a few minutes to talk to you about the Texas experience that we've had since 1975.

In 1975 the vocational rehabilitation division of our agency, which is the division that carries out the basic vocational rehabilitation program, had 1,600 employees, 593 vocational rehabilitation counselors. That was one counselor for every 29,000 population. At that time only 32 percent of the individuals we were rehabilitating were in the severely disabled category.

In comparision, we went from 593 counselors in 1975 to 345 counselors in January 1983, or 1 counselor for every 45,000 population. However, the percentage of severely disabled has reached 62 percent. We've gone from 32 percent in 1975 to 62 percent in 1983.

In fiscal year 1982 the Texas Rehabilitation Commission and staff of the commission, rehabilitated 13,908 individuals into employment. Again, as I told you, 62 percent of the individuals we're serving now are severely disabled. The 13,908 has a 96-percent verification factor, which means I have an evaluation team, a program evaluation team that reports directly to me, that verifies employment and closures in this program, and I can document a 96-percent verification on this number I gave you.

Twenty-four percent of the 13,908 individuals that we rehabilitated in 1982 had a monthly income of $1.7 million when they were accepted; 38 percent of the $1.7 million was from some form of State or Federal tax supported programs.

After rehabilitation, the 13,908 individuals had an income of $9.6 million per month or 5½ times as much as before they were accepted, and as has already been stated here, each one of these individuals over the work history of their lifetime will pay back $10 for every dollar invested in them through our rehab program. We feel that this is an investment, this is an investment in human energy, in human potential, in human dignity.

The vocational rehabilitation program in Texas, and I'm sure throughout the States, does not work—throughout the country—does not work in a vacuum. We have some very good partners. We have a very strong Federal/State partnership in our part of the country. We also have a very strong partnership with our consumer groups.

Mr. Lex Frieden, who I believe testified earlier in the week, is chairman of my consumer consultation committee, and we also work very closely with Mr. Justin Dart, who is the chairman of the Governor's Committee on Employment of the Handicapped.

With the help of these two organizations and 28 other consumer groups we have designed and implemented a program that I feel is unparalleled for the disabled handicapped community of our State and the country.

There has been some talk about efficiency and, again, I'd like to continue talking just a little bit about the Texas experience. Our previous Governor, Mr. William Clements, initiated a program in our State called the State government effectiveness program. It was a program implemented by the Governor to enhance and try to bring into practice in State government good, sound, business management practices.

In a called board meeting, Governor Clements recognized the Texas Rehabilitation Commission as the outstanding agency in implementing his State government effectiveness program, and I only mention that to you to let you know that the vocational rehabilitation programs in this country are effective; they are efficient; they are tried; they are proven.

Given the right amount of funding and the continuation of the Rehabilitation Act, we will continue to serve the disabled community of our State and this country, I think, in a fashion that you will be proud of and that will be in the best interest of the severely disabled of Texas and the country.

Thank you, Mr. Chairman.

Mr. SIMON. We thank all of you very, very much. I don't mean to be cutting off any questions here of any member, but we are going to have to move to the markup very shortly. Do any members have questions?

Mr. MILLER. I do, Mr. Chairman.

Mr. SIMON. Mr. Miller?

Mr. MILLER. I'd like to say for the record that, given the testimony of this panel and the historical trends that you mentioned earlier that show we clearly have been moving over the last 5 or 6 years to a much higher percentage of the severely disabled in cases that have been served, it's a little bit contrary to what the administration has suggested, at least in their letter to the Speaker of the House, when they transmitted their proposals.

They recognized that to rehabilitate the more severely disabled is more costly. Yet they failed to provide additional funding for this purpose, whether it's under a flexible means or any other means.

At the same time they cite a GAO report where they provide that 35 percent of the cases have no apparent relationship between the clients' job at closure and the vocational rehabilitative services.

Granted, I'd like that to be improved, but that also suggests that 65 percent of the cases do have this relationship and that encompasses both the severely disabled and the nonseverely disabled.

I find it interesting that this administration would have us choose between the disabled and the severely disabled. I think what most people in the field would suggest is they both need similar types of services, some more intensively than others.

Finally, I think California does about as good a job as anyone, but I'm concerned after the testimony from Florida that under this incentive grant program all the money would end up in Florida. [Laughter.]

Mr. MILLER. If you turn out a couple more electronic engineers, I think at that point you win all of the money in the pool.

But I think it's interesting that they decide they are going to provide an incentive program based upon the incomes of the individuals who are employed. Apparently they don't recognize a differential here with whether or not it's an entry-level job that may lead to a career. That would not be as rewarded as much as a temporarily high placed job of 120 days.

It's also interesting that while they're going to give the financial incentives to the States under their program, they make it more difficult to achieve those levels. Rather than 60 days, apparently from the prior testimony, it's going to go to 120 days. You get rewarded if you place somebody over the minimum wage, but it indicates that they expect to expand the exemptions from the minimum wage.

If you look at their proposal, what you find out about the incentive for States who need this rehabilitative money, is that three unpaid homemakers are worth two people working above the minimum wage. So to keep the flow of funds coming into your State you must then, all of a sudden, start targeting toward total numbers rather than placement and you can get reimbursed. So, if you place enough people at less than the minimum wage you will do just as well as if you evenly target your services and try to recognize the need for services. This is the most asinine program I've ever read. [Laughter.]

I just think that it has no bearing on what happens with people who work in the field of trying to rehabilitate the handicapped. It's not an easy field to work in. We see the historical trends which the Congress has tried to encourage through this act, and that States are endeavoring to meet those. We see up to 60 percent of the severely disabled receiving services in 1982, even under the budget constraints that have been outlined by the panel, and I would just hope that we would follow the chairman of this committee's direction and reject this proposal. I think there are going to be some amendments by Mr. Bartlett and others to improve it at the full committee level and I would hope that we would move in that direction.

As the southerners in the Congress are so fond of saying, "If it ain't broke, don't fix it." [Laughter.]

Mr. MILLER. I think that may apply to this case.

I'm done.

Mr. SIMON. Mr. Corrada?

Mr. CORRADA. Mr. Chairman, I don't have any questions but I would like to state my appreciation to all of the members of the panel for their very impressive testimony. I believe that we should be ready to get on with the business of the day by promptly passing this bill here at the subcommittee level and moving it on to the full committee.

I would hope, Mr. Chairman, that we would not tamper with a program that has worked well. What we need is to restore funding levels that, based on the cost of living increases, were prevailing in 1979 and I agree with some of the statements made here that they need neither more flexibility nor more incentives. What more flexibility or incentives do you want for people who are out there in the field working with those that they serve directly? I, therefore, would like to state in commending the witnesses about their testimony that I intend to fully support this reauthorization and the efforts of the committee to move this bill promptly in this Congress.

Thank you, Mr. Chairman.

Mr. SIMON. Thank you.

Mr. Bartlett, do you have any comments or questions?

Mr. BARTLETT. Mr. Chairman, I have some questions of the panel and some thoughts and ideas for during markup which I will say to several members on the other side of the aisle.

Mr. Erlenborn had mentioned to me on the way back to the floor that he, of course, has to be on the floor because of the importance of the budget debate, and also, of course, has to be in markup today, and we are trying to get word from him now as to what is happening on the floor, I think Mr. Murphy is in the same position. So whether we go through markup today or delay it for a short period of time, I'd leave to your discretion.

Here comes the chairman now.

Mr. MURPHY. OK. We're just about ready.

Mr. BARTLETT. Mr. Chairman, you missed the finest presentation based on the Texas experience that I believe I've ever heard. [Laughter.]

Mr. MURPHY. I apologize to the panel. We have a markup going on in the Interior Committee as well.

Mr. BARTLETT. I do have some questions of an exploratory nature because these four, this panel, represent people who are on the front lines. Then, as far as my preference, we can either go to markup or wait and do markup at a future time. I'd leave that to the discretion of the chairman. I'm prepared either way.

As to the flexibility question, I suppose I'd like to explore that with the four of you a little bit more and to see if you all concur or whether there are areas of difference. And maybe, since Mr. Miller has expressed reservations about that word, we could come up with a better word, with a word that might indicate allowing the States to use more of your limited resources on direct services and less of your limited resources on requirements that don't make sense for your State.

My question is do your States or do other States that you know of find problems and have to add costs that you believe are unnecessary to comply with the statute. For example, one of the items contained in the law which the administration bill proposed to take out, is the requirement that you provide, and I am quoting here, "At a minimum for the provision of the vocational rehabilitation services specified in clauses one through three," and also of subsection A of 103 and then it gives a laundry list, as you all are well aware, evaluation, counseling, vocational—several pages of requirements.

This is obviously very serious and very central to your operation and so I suppose I would seek to learn from you whether these requirements add to your costs unnecessarily or, in fact, you would provide those anyway even if these requirements were deleted from Federal law?

Mr. **Bartels**. Mr. Chairman, the Council of State Administrators of Vocational Rehabilitation have reviewed the act of 1973 with the services that are recommended. We have also looked at many of the regulations that define the program in further specificity, and have no recommendations on where they should be changed. We are very comfortable with the Rehabilitation Act.

Speaking from my perspective as head of the agency in Massachusetts, if those services were deleted from the Rehabilitation Act, they would continue to be carried out in the Commonwealth of Massachusetts, and I would expect that that would be the case in every other voc-rehab agency around the country.

What is in the act of 1973 is based upon a long history and experience of good vocational rehabilitation programing. From our perspective that should remain in there.

Mr. **Bartlett**. So the States that you represent and that you've talked with don't find those clauses to be burdensome administratively in any way?

Mr. **Bartels**. No, they don't.

Ms. **Krajczar**. Not at all.

Mr. **Wedewer**. No, Mr. Chairman, or Mr. Bartlett. I haven't heard any of my staff complain about it or any of the other States in the South. There isn't really a problem with that. We're going to provide the services, as Mr. Bartlett said, and we're going to try to rehabilitate people, whether it's a laundry list or not. We're going to provide those services to get them to that bottom line, which is employment and independence.

We don't have any problem with it and I think probably we're faced with a problem that isn't a problem. I don't recognize the problem.

Mr. **Bartlett**. Well, Mr. Miller has so eloquently tripped me up by my favorite expression of, "If it ain't broke, don't fix it," so I will move on to another——

Mr. **Miller**. See, you guys have an impact on the North here. [Laughter.]

Ms. **Krajczar**. Mr. Congressman, if I may, I think you're addressing yourself to the issue of accountability and I would suggest that it would be certainly expected of me as a public administrator in the State of New Jersey to be equally accountable to the taxpayers and the administration of my State as we are to the Federal Government in this instance in the kinds of issues that you are discussing.

Mr. **Arrell**. I would also suggest that we are accountable to the consumers in our State and I would suggest that leaving the things delineated would be in the best interest of the disabled handicapped community.

Mr. **Bartlett**. Leaving these clauses in Federal law?

Mr. **Arrell**. Yes.

Ms. **Krajczar**. Yes.

Mr. **Arrell**. I believe it would be in the best interest to leave them. It gives a protection to the severely disabled, I think, that they deserve.

Mr. **Bartlett**. Thank you.

Mr. **Arrell**. Mr. Chairman, it appears as though the administration is making some proposed changes just for the sake of making changes, that really have no bearing in fact with respect to program operations.

Mr. **Bartlett**. Have your States and others—it's been my general impression but I don't have any way to quantify it—can you quantify the increases that you have received from your State legislatures in the past several years, and are you still receiving increases in funding from your State legislatures? I know that there are—I don't know of any States that are merely doing the minimum of the 20-percent matching, but as I understand the matching, it runs anywhere from 26 to 55 percent. Do you find the State legislatures to be increasingly receptive?

Mr. **Arrell**. Mr. Congressman, as you know in our State, the last session of the legislature did increase our funding. The legislature today in our State is marking up my bill, this afternoon, and I will know a little bit more about it tomorrow. But I do anticipate an increase.

Mr. **Bartlett**. You do anticipate an increase?

Mr. **Arrell**. Yes, sir.

Mr. **Bartlett**. Another subject which was not raised—I am sorry, it was raised today, almost tangentially—and that is if there were a way, and this is not in this bill, but if there were a way over the next session of this Congress to find a way to use existing funds that are spent through various entitlement programs—whether it's social security or SSI or other entitlement types of programs—and use those existing funds for rehabilitation purposes and therefore decrease the amount of entitlement money in the future that's required, would that be a direction that you would urge this Congress to go? It was mentioned in testimony on Monday and it may be something that this committee or other committees of Congress may explore in the next 12 months.

Mr. **Arrell**. I would think, if I could speak, that that would be a very good possibility. I think with one danger in that, and I would want to be very careful about it, taking money away from those programs that perhaps we use as other sources. In other words, we utilize a tremendous number of other programs to help supplement our program to rehabilitate people, and I don't think it would be a wise decision to take money away from some of those programs that we use now to help supplement the rehabilitation program or help us carry out our program. I think we'd just be shifting money from one place to another.

Mr. **Bartlett**. So you would urge caution?

Mr. **Arrell**. Very much.

Mr. **Bartlett**. But some exploration of the idea?

Mr. **Arrell**. Not knowing the details, I would say that there is a possibility that some of that could be done, but I would be very cautious.

Mr. **Bartlett**. Because on the back side, if we were to—when you successfully rehabilitate someone and get them into permanent employment, you then dramatically decrease the amount of entitlement funding that's required. So there should be some way to almost advance the money from the Government to itself and allow people to lead more productive and satisfying lives and also save the Government money.

Mr. **Arrell**. Of course, that's the premise that we worked on in the social security program—that if we rehabilitated those people on social security then they would be taken off of social security and would no longer be drawing that money.

Mr. **Bartlett**. In title VI do you believe that state agencies ought to be allowed to be eligible for projects with industry funding, PWI funding?

Mr. **Arrell**. Yes.

Mr. **Bartlett**. You do?

Mr. **Arrell**. Yes, sir.

Mr. **Bartlett**. Have any of your States applied for this?

Mr. **Arrell**. Yes.

Ms. **Krajczar**. Yes.

Mr. **Wedewer**. Yes; Florida has.

Mr. **Bartlett**. Texas has, Florida has. OK.

In the part B part, in the part A, back on to title VII, the way the part A is written now, only 20 percent, as I recall, of part A money would be required to be used in part B centers. If we were to somehow prevail upon the Appropriations Committee in restructuring that section and prevail upon appropriations to fund part A, would part B centers have been so effective and if they have proven themselves so well would you anticipate wanting to use more of that part A money to just permanently fund part B centers, the independent living centers?

Mr. **Arrell**. I think we'd look to a combination of continuing funding in part B to make sure that the centers were funded, at the same time that part A was brought into play to begin planning for a fullscale part A service delivery system for the next fiscal year and the subsequent 2 or 3. So I think it would have to be a combination of those points.

Mr. **Bartlett**. One last question. On page 3 of your prepared testimony, of your written testimony, you asked for a 3-year extension of the act rather than permanent authorization. Is that because you would anticipate in 3 years being able to come up and again testify before Congress and, if nothing else, find just technical amendments or cleanup amendments or ways to improve the program every 3 years? Was that a deliberate testimony on your part?

Ms. **Krajczar**. I believe, Mr. Bartlett, that the wording suggests a minimum of 3 years and I think that our concern or the concern of the Council of State Administrators at this point in time is to try to act with some dispatch in addressing the critical nature of the timing that's before us and to suggest perhaps a no-end extension at this time was beyond our capability to design, although certainly we would be more than happy to entertain that kind of thinking on the part of the committee.

Mr. **Arrell**. We would not oppose that. [Laughter.]

Mr. **Bartlett**. Thank you, Mr. Chairman. I yield back the balance of my time, if any.

Mr. **Murphy**. Thank you, Mr. Bartlett. We are going to move to a markup as soon as the committee is ready. Are there any remaining questions of the panel?

OK, the panel is dismissed with our thanks for being with us today and for giving us some great insight into the reauthorization. Thank you, ladies and gentlemen. We will immediately proceed to mark up. We have more members here than is usual and I think it shows the concern that all of the members have on this very vital reauthorization.

[The prepared statements submitted for inclusion in the record follow:]

PREPARED STATEMENT OF GARY L. BAUER, DEPUTY UNDER SECRETARY FOR PLANNING, BUDGET, AND EVALUATION, DEPARTMENT OF EDUCATION

Mr. Chairman and Members of the Committee:

I am pleased to present testimony for the Department of Education on the subject of reauthorization of the Rehabilitation Act of 1973, as amended. The Act presently authorizes programs of the Rehabilitation Services Administration (RSA), the National Institute of Handicapped Research, and the activities of the National Council on the Handicapped.

The Rehabilitation Act of 1973, as amended, authorizes the allocation of Federal funds on a formula basis to States to provide services to assist disabled individuals to prepare for and engage in gainful occupations. Significant progress has been achieved over six decades to develop a service delivery system in the States to rehabilitate disabled persons. However, we are proposing amendments to the Act as part of our reauthorization effort because we believe there is room for improvement in the rehabilitation outcomes that can be achieved for the severely disabled.

For example, about three-quarters of all rehabilitants are placed in the competitive labor market; for the severely disabled the proportion is about 6' percent. In fiscal year 1981, the mean weekly earnings at closure of severely disabled rehabilitants with earnings was $148; for the nonseverely disabled, $168. These figures understate

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the actual hourly wage rates since many rehabilitated persons work only on a part-time basis. Nevertheless, over one-half of the severely disabled rehabilitants received less than the Federal minimum wage in 1981, while 21 percent received no wages at all at case closure. In the last two years, increasing proportions of the severely disabled have been placed as unpaid homemakers.

Current law simply does not provide adequate incentives for State rehabilitation agencies and professionals to provide services that produce lasting functional and economic independence at the highest possible levels to the most severely handicapped clients. Regardless of performance, the States receive their funds according to a formula based on population and per capita income. The current measure of success used by the program assigns credit on an overly simplistic basis by combining into a single category employment in the competitive job market, in sheltered workshops, unpaid work of homemakers and unpaid family work. Moreover, the definition of successful rehabilitation only requires 60 days in employment.

Several audits and evaluation reports have also indicated that changes are needed in the current rehabilitation system to improve rehabilitation outcomes, especially for the most severely disabled. In 1976, the General Accounting Office (GAO) reported to the Senate Subcommittee on the Handicapped that since counselors have traditionally been rated on the basis of the number of persons they rehabilitate and the severely disabled are more costly to rehabilitate, counselors would naturally have some reluctance to allocate a significant portion of their resources to

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rehabilitating the severely disabled, which would result in rehabilitating a smaller number of clients. GAO noted that rehabilitation counselors believe that a system which accounted for the cost and difficulty of the cases would give added incentive to increasing services to the severely handicapped since the emphasis on sheer numbers would be reduced.

In 1978, Berkeley Planning Associates reported that rehabilitated clients were often placed in jobs that are low paying, unstable, or not in conformity with the original employment objectives. They concluded that if meaningful rehabilitation is to be achieved for more clients, an incentive must be provided for counselors to pursue services which assure that clients achieve stable employment with earnings of at least the minimum wage. The Berkeley Report suggested the introduction of a performance measure that directly appraises the quality of client services or outcomes such as the wage level or whether the benefits are retained over time.

In 1982, the GAO reviewed a sample of rehabilitated clients in five States and found that in 35% of the cases there was no apparent relationship between the client's job at closure and the vocational rehabilitation services provided. Other problems identified by GAO included failure of State rehabilitation agencies to observe the requirements for eligibility and case closure as well as identifying the use of similar benefits. Similar problems have been reported in 1973 and 1979 by the Department of Health and Human Services' internal audit agency. GAO recommended that the administration of the Vocational Rehabilitation program be strengthened to provide services only to individuals who have substantial handicaps to employment and can reasonably be expected to become gainfully employed.

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The Department recommends that the Congress consider changes to the Rehabilitation Act of 1973, as amended, that would advance the following principles:

- reward States for good performance in rehabilitating the severely disabled;
- establish a more meaningful measure of program success capable of influencing the talents and energies of State vocational rehabilitation agencies, which will ultimately produce greater functional and economic independence for disabled clients;
- provide greater State flexibility in the provision of services; and
- promote stricter accountability to standards in such areas as client eligibility and case closure standards for successful rehabilitation.

We propose that Title I be amended to reward State performance in rehabilitating the severely disabled by distributing part of the funds appropriated for State grants on the basis of a weighted case closure system. Beginning in 1985, one third of the State grant funds would be allocated to the States on the basis of their performance in rehabilitating the severely disabled. Rehabilitations would be weighted to maximize the financial incentive for placement in jobs that achieve economic independence. Rehabilitations resulting in employment at or above the Federal minimum wage (which would incorporate statutory or

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regulatory exceptions for sheltered workshops and work activity centers) would receive a weight of 1.5. Each rehabilitation resulting in employment below the Federal minimum wage would receive a weight of 1.0. In recognition of the economic and independence value of unpaid homemaking and family work, these rehabilitations would receive a weight of .5. To assure that employment outcomes are stable as well as financially rewarding, the definition of successful rehabilitation would be strengthened to require 120 instead of 60 days of employment. The remaining two-thirds of the appropriation would be allotted to the States using a simplified version of the current formula based on population and per capita income squared. To provide sufficient time for the States to adjust to the proposed changes in the formula, hold harmless provisions have been included for fiscal years 1985 and 1986.

We are also proposing changes to take effect in fiscal year 1984 designed to provide greater State flexibility in the planning, administration, organization, and delivery of rehabilitation services. For example, the amendments retain the requirement for a sole State agency to administer the program, but eliminate the detailed provisions prescribing how that agency is to be organized and administered. The bill would also eliminate a number of State plan provisions which address administrative issues we believe are better left to State discretion. These include: the requirements for maintenance of personnel standards, application of the plan in all subdivisions of the State, and the provision of mechanisms for cooperative agreements. The amendments would continue to allow a State agency to provide any or all of the services described in section 103 of the Act, but would not require

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the State agency to provide certain "minimum services" as a part of its rehabilitation program. Instead, we believe that performance based funding would give States the incentive to provide services necessary to achieve rehabilitation of its disabled citizens. In order to continue to ensure the maximum utilization of Federal rehabilitation dollars, the bill would continue to require that States make use of similar benefits available under other programs and maximum use of other public and private resources in the State and community.

The bill would retain and improve the provisions which provide protections and rights for the handicapped. The bill would retain requirements relating to the priority for providing services to the severely disabled, the individualized written rehabilitation program, the availability of personnel trained to communicate in the client's native language, the prohibition against residence requirements, the review of sheltered workshop closures, and affirmative action for the employment of qualified handicapped individuals. The bill would revise appeal procedures concerning State review of agency determinations to include both determinations concerning eligibility of an individual as well as the appropriateness of the rehabilitation services provided. The bill would also add a provision requiring the State agency to provide client assistance services to all clients and client applicants, including information and advice concerning the benefits available under the Act, assistance in pursuing legal, administrative, or other remedies under this Act, and appropriate referrals to other State and Federal programs. In addition, the bill includes a new provision protecting the confidentiality of personal information provided by clients to counselors and agencies.

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In order to provide for the continued development of a comprehensive and coordinated program of handicapped research and the dissemination of information on the most effective practices, Title II authorizing the conduct of handicapped research through a National Institute of Handicapped Research is retained under the bill. The bill would extend the authorization of appropriations for handicapped research under Title II through fiscal year 1988. The bill would continue to provide that the National Institute of Handicapped Research could pay for all, as well as for part of the cost of research and demonstration projects. The bill retains Title IV authorizing a National Council on the Handicapped, but provides that the Council would provide advice to, rather than establish general policies for, the Institute of Handicapped Research. This change would make the Council's role consistent with other such councils in the Department.

A variety of existing discretionary programs are included in Title III under a single authorization of appropriations. The purpose of Title III is to authorize grants for projects of national or regional significance or projects to meet the unique needs of special handicapped populations. It includes authorizations for the following activities: Training, Grants to Indians, Projects with Industry, Centers for Independent Living, Special Demonstration Programs (including Projects for the Severely Disabled), Migratory Workers, the Helen Keller National Center, and Special Recreational programs. Title III also includes authority for the Commissioner to provide consultative services and technical assistance, to provide for the collection and dissemination of information, and to evaluate any of the programs or activities carried out under the Act.

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Although we are not proposing to change the scope or types of activities funded under these authorities, we are proposing some modifications. For example, we are proposing to extend eligibility for grants and contracts under these activities to for-profit organizations. We are also proposing to eliminate specified matching rates and to authorize the use of Federal funds to pay all or part of the costs of projects funded under these programs. In the Training program, we are proposing to delete the specific requirements concerning the types of projects and application content in order to enable us to focus resources on the most critical training needs. In the Independent Living program, we are proposing to eliminate the statutory priority for agencies designated in the State plan in order to open up eligibility to a variety of State, public, and private organizations. The bill would also remove unfunded or duplicative authorities.

For the longer term, it is the Administration's goal to reorganize Federal-State delivery of rehabilitation services by returning revenue sources and full program authority to the States. On February 24, the Administration transmitted proposed legislation to the Congress that would give States the option of designating a number of programs for turnback during the period 1984 through 1988. The Vocational Rehabilitation (VR) program is included in the list of programs that may be designated by participating States because the Administration believes the ultimate responsibility for rehabilitating the disabled population can appropriately be assumed by the States. Rehabilitation services have long been delivered by State agencies. States can best determine the rehabilitation needs of their own citizens and the means of making them employable. It is thus appropriate to include VR in the Federalism proposal.

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States that initially choose not to designate VR as part of their State block grant under Federalism would operate the program under current law. For these States (for all States should Federalism not be enacted), we are proposing amendments which we believe will help the States to develop stronger, more effective programs.

In summary, we believe the Administration's proposal would improve rehabilitation outcomes for the disabled by enhancing the both the incentive and the capability of State agencies to make the most effective use of Federal, State and local resources in serving the disabled. The bill is designed both to simplify the administration of the program and strengthen achievement of program goals. We appreciate this opportunity to discuss our proposal with the Committee and hope that you will give it favorable consideration.

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Statement Presented by Norma F. Krajczar, Executive Director, New Jersey Commission for the Blind, on Behalf of Council of State Administrators of Vocational Rehabilitation

The Council of State Administrators is an association comprised of the chief administrators of the public rehabilitation agencies for physically and mentally handicapped persons in all the states, the District of Columbia, and our Nation's territories. These agencies constitute the State partners in the State-Federal Program of Rehabilitation authorized by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, Public Law 95-602, as amended.

Since its inception in 1940, the Council has enjoyed a quasi-official status as an active advisor to the Federal administrators in the formulation of national policy and program decisions and has been an active force in strengthening the effectiveness of service programs for disabled Americans. The Council also serves as a forum for State Rehabilitation Administrators to study, deliberate, and act upon matters bearing upon the successful rehabilitation of persons with disabilities.

The core of America's Rehabilitation Program is the 63-year old State-Federal Program devoted to providing a combination of rehabilitation services to physically and/or mentally disabled adults. At the center of this Program is the State Rehabilitation Agency which provides for a wide range of services for eligible, disabled persons. Most often these services are provided with the cooperation of, or through, private, non-profit service providers.

The primary purpose of the provision of vocational rehabilitation services is to render "employable" those persons with disabilities who, because of the severity of their handicaps, are unable to secure and to hold employment.

The Rehabilitation Act is the most complete and well-balanced legislation in the human services field.

In one Act, there are included provisions for a comprehensive and individually-tailored program of vocational rehabilitation services to individuals with physical and/or mental disabilities; an innovation and expansion program; a training program; a research program; a rehabilitation facility program; a program providing comprehensive services in independent living; a community services employment program; and a special projects program.

Experience has shown that this balanced approach embodies all of the elements necessary for the successful rehabilitation of persons with disabilities.

Essential, of course, to maintaining this balance is a well-funded program of direct services to help individuals with disabilities become employable. It is vital that this program have strong, experienced and effective National leadership. However, there must also be research to reveal new knowledge; special demonstration projects to test this knowledge in practical settings; trained personnel to work with persons who are disabled; and a comprehensive program providing independent living services to persons who are so severely disabled that they cannot benefit from traditional rehabilitation services. Agencies must also be encouraged to initiate new programs and expand existing ones to apply new knowledge to new groups of individuals with disabilities. Likewise, rehabilitation facilities must be developed or improved, in which severely disabled individuals may be served with optimum care and expertise.

It is this balanced approach which enables the rehabilitation movement to make the widely-acclaimed progress that has been evident throughout its history.

The Council of State Administrators of Vocational Rehabilitation fully supports each facet of this process and every provision of the Rehabilitation Act.

EXTENSION OF THE ACT

We are here to strongly urge the extension of the Rehabilitation Act of 1973, as amended, for a minimum of, at least, three years. This will provide authorization levels through Fiscal Year 1986. This extension is needed to insure program stability in the State-Federal Rehabilitation Program and to continue the provision of quality services to the millions of disabled Americans who are in desperate need of rehabilitation.

The Rehabilitation Act of 1973, as amended, is a model of what can be done in the human services field. We are of the strong contention that to amend or rescind portions of this law might severely unsettle the balance that makes this program one of the most--if not the most--balanced program in the human services area, as well as one of the most effective.

We further urge swift action on the part of the Congress in the reauthorization of this law. It is imperative that the states be given the necessary lead time in planning for future needs. State legislatures, many of which will be in session for short, specified periods of time, require advance knowledge of Federal Authorization levels for future years in order to provide the state matching financial contributions. Early reauthorization by the U.S. Congress will have a significant, favorable impact on state appropriations and programmatic decisions affecting the rehabilitation program for future years.

The need for the extension of the Rehabilitation Act is but one of the three main needs of the Vocational Rehabilitation Program, for any program must have at least three main pillars to support its effective operation. It needs wise enabling legislation, effective leadership, and adequate appropriations.

During the past several years, the Rehabilitation Program has been without effective, strong leadership at the Federal level. The State-Federal Rehabilitation Program--in fact any program--vitally needs strong, committed, and knowledgeable national leadership. We look to the current Administration, as we have looked to past Administrations, to provide this.

It is also vitally important that the U.S. Congress appropriate funds that will enable the State-Federal Rehabilitation Program to serve as many individuals who are eligible for rehabilitation services, as is possible.

For the past few years, the number of persons served and rehabilitated has been decreasing. This unfortunate--indeed tragic--occurrence can be attributed to the continually-rising costs of doing business resulting from years of suppressed funding and debilitating inflation; the growing focus of the states on serving more severely disabled individuals; and the recent loss of over $100 million annually in direct service monies by the amending of the Social Security Vocational Rehabilitation Programs.

Despite present expenditures, there still are not sufficient funds to serve all those eligible, disabled persons who have the potential and desire to work and who need rehabilitation services to attain employment or self-sufficiency.

Alarmingly enough, our best estimate is that State Rehabilitation Agencies are only able to serve one out of every twenty persons who are eligible for services.

We are sure that there does not exist any sector of our Nation's workforce which is experiencing more unemployment than that experienced by persons with disabilities.

The Council strongly recommends that the Congress provide legislation which contains authorization levels for the Basic State Vocational Rehabilitation Program that will help to reverse the decreasing number of persons who are being served and rehabilitated into employment and assist in addressing the severe and debilitating employment problems which face persons with disabilities.

The Council recommends that the legislation extending the Rehabilitation Act contain authorizations for Basic State Grants under Section 100(b)(1) of the Rehabilitation Act of 1973, as amended, equal to $1,037.8 million in Fiscal Year 1984; $1,141.1 million in Fiscal Year 1985; and $1,254.6 million in Fiscal Year 1986.

It is vital that this Subcommittee and other Members of the Congress understand the rationale behind this organization's recommendations for authorization amounts for Vocational Rehabilitation Services for the next three fiscal years.

Advocates, when giving serious consideration to their recommendations for service monies, are always torn between basing such figures upon need or tempering that need with economic restraints placed upon those who control Federal.

appropriations.

Our recommendations would work to achieve the goal of restoring the purchasing power of the Rehabilitation dollar to the 1979 Section 110 Federal spending level. To achieve this, increases in Section 110 funding would have to occur for the next four fiscal years, at a rate equal to the above authorization recommendations, which average approximately 9.95 percent per year.

Fiscal Year 1979 is viewed as the last year in which the State-Federal Rehabilitation Program operated at full strength, for ever since that year, there has been a steady decline in the number and types of persons with disabilities who have been served, due to economic and programmatic factors.

We have utilized this "formula" for our recommendations, thereby attempting to balance "need" with the reality of the current economic climate.

While the Council of State Administrators is recommending--based upon need as well as fiscal reality--authorization levels for many other provisions of the Rehabilitation Act in the chart attached to this written testimony, we do wish to highlight the importance of Title VII of the Act.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

This section establishes a state grant program to meet the current and future needs of individuals with disabilities so severe that they do not presently have the potential for employment, but may benefit from rehabilitation services in order to live and function independently.

When this law was enacted, a substantial new service program was envisioned with, as the U.S. Senate Report declared, "sufficient funds" available to develop "effective long-range plans and services." Such funds have never been made available.

The time to implement a new Comprehensive Services Program is now. The existing Independent Living Centers across the country have proven--and continue to prove on a daily basis--the effectiveness of, and the need for, the full implementation of the Independent living concept.

We need desperately to supplement the services provided by the existing Centers. This can be done by implementing the already authorized--yet unfunded--statewide service delivery system in independent living for the severely disabled, under Title VII, Part A.

The CSAVR's recommendation of a $60 million authorization for FY 1984 for this program is justified based on the need for devising an equitable state distribution procedure for Part A Service Grants; allowing a continued adequate funding base for the Centers for Independent Living as authorized under Part B; and funding for the first time an Older Blind Individuals' Program, as authorized by Part C.

Our recommendations for authorizations for Title VII for Fiscal Years 1985 and 1986, would also provide modest increases in each of the Programs established under this Title. We urge that they be given every consideration.

RECOMMENDATIONS FOR OTHER PROVISIONS OF THE ACT

The Council, in conjunction with many organizations representing service providers and persons with mental and/or physical disabilities, has agreed upon recommendations for many of the other programs established under the Rehabilitation Act.

As has been stated previously, each of the provisions in this well-written statute is important to the entire mosaic of rehabilitation services.

This organization yields to no other in advocating the importance of each of these programs; however, we do leave to others the role of presentation to you and the Congress of testimony outlining the need for a continuation of each.

SUMMARY

Our justification for higher authorization amounts arises from the purpose for which the money is spent -- the prevention of an incalculable waste of human potential, a purpose on which no price tag can be placed.

Whatever the cost, there is no other human service program whose funds are spent in such a cost-effective manner to help people to live more self-sufficient and productive lives.

Vocational Rehabilitation has consistently more than paid for itself by helping persons with disabilities increase their earning capacity, by decreasing the amount of public assistance payments they might need, and by assisting them to become taxpayers.

Moreover, the value of rehabilitating a person's spirit and life, is, above all else, immeasurable.

The need is desperate. For the past months, all have heard reports of the high levels of unemployment that our Nation endures.

Unemployment is now hovering at a level near or above that of the Great Depression. Currently, more than one person in ten is out of work. In some cities and states, and among some minorities and other societal groups, unemployment is much higher, ranging from twenty to as high as fifty percent.

Out of need, the nation is responding to this tragedy. The President and the Congress have apparently reached agreement on Public Jobs legislation to provide relief to those individuals and their families who have been affected by this Recession.

However, we must also recognize that there does not exist in our society any group of persons who are experiencing more unemployment than that which is experienced by persons with disabilities.

To begin to adequately address the severe and debilitating employment problems of persons with disabilities, the Congress must act swiftly to maintain and enhance the foundation of the only major Federal program that exists to provide vital, desperately-needed services to persons with disabilities for the primary purpose of rendering them "employed."

The Rehabilitation Program has a successful, sixty-three year history of providing, literally, any service demand necessary to bridge the gap between dependency and independence and employment.

It would be tragic to become mired in the "process" of extending the Rehabilitation Act of 1973, as amended. The task before us is clear, and great -- to prevent the incalculable waste of human potential.

The solution, perhaps the best that government could ever hope to offer, is before us in the form of a well-balanced State-Federal-Private Sector Rehabilitation Program. One that continues to provide comprehensive, cost-effective, humane, and desperately-needed services at the community level to persons with mental and physical disabilities who desire to work, but lack the training, occupational skills and other services required to actively compete in the labor force.

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION
RECOMMENDATIONS FOR AUTHORIZATIONS OF PROGRAMS ESTABLISHED BY THE REHABILITATION ACT FOR FISCAL YEARS 1984, 1985, and 1986

(in millions)

ITEM	Proposed FY 1984	Proposed FY 1985	Proposed FY 1986
BASIC VOCATIONAL REHABILITATION SERVICES (Sec. 100(b)(1)	$1,037.8	$1,141.1	$1,254.6
CLIENT ASSISTANCE PROJECTS (Sec. 112(a)	3.5	3.5	3.5
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH (Sec. 201(a)(1)	40.0	50.0	60.0
TRAINING PROGRAM (Sec. 304(e)	25.5	30.5	35.5
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING (Title VII)	60.0	90.0	120.0
ALL OTHER PROGRAMS IN ACT (Various Sections)	"such sums"	"such sums"	"such sums"

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[Whereupon, at 11:40 a.m., March 23, 1983, the hearing was adjourned.]

APPENDIX

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION
Suite 401, 1055 Thomas Jefferson Street, N.W., Washington, DC 20007
Telephone 202-638-4634

Executive Director
Joseph H. Owens, Jr.

April 7, 1983

Hon. Austin J. Murphy
Chairman
Subcommittee on Select Education
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Officials of the Department of Education and the Rehabilitation Services Administration presented testimony on March 23, before the House Subcommittee on Select Education, relative to the Rehabilitation Act of 1973, as amended.

During that testimony, RSA Commissioner George Conn stated in his remarks that this organization, the Council of State Administrators of Vocational Rehabilitation (CSAVR), is working cooperatively with the RSA. Placed in juxtaposition to Mr. Conn's comments are the recommendations of the Administration for amendments to the Act, implying that there is, at least, tacit approval of them or the need for them by this organization.

As President of the CSAVR, I wish to state as emphatically as is possible that this organization does not support the Administration's proposals and has made this known to the Commissioner on many occasions.

We do not wish to have the Subcommittee or the full Committee misled by Mr. Conn's remarks that the CSAVR is a willing partner in altering the Rehabilitation Act of 1973.

In summary, the view of this organization is clearly stated in its written testimony provided, by invitation, to the Subcommittee that it "fully supports each facet of the (rehabilitation process) and every provision of the Rehabilitation Act."

Sincerely,

Peter P. Griswold

Peter P. Griswold
President

Membership consists of the chief administrative officers of the state rehabilitation agencies responsible
for administration of the state-federal rehabilitation programs in each of the states

National Rehabilitation Association

633 South Washington Street
Alexandria, VA 22314
(703) 836-0850

David L. Mills
Executive Director

March 21, 1983

Representative Austin Murphy
Chairman
House Education and Labor Committee
Subcommittee on Select Education
Washington, D.C. 20515

Dear Representative Murphy:

Thank you very much for the opportunity to present the views of National Rehabilitation Association related to the Rehabilitation Act of 1973 as amended. I was most impressed with the interest shown by you and members of the Subcommittee in the Act in its entirety.

I have some added comments relative to Title VII that I thought I would communicate to you.

Currently, only Part B of Title VII is funded. These funds are issued to support 135 Centers for Independent Living across the country. We urge that Part A, as well, be funded, which will, as a result of the language in the Act cause Part B to be implemented.

We recommend that 33 million dollars be authorized for Part A; 24 million dollars be authorized for Part B and 3 million dollars be authorized for Part C.

Funding for Part A will provide a vital link between the Centers for Independent Living and the State Vocational Rehabilitation Agencies. It will afford persons with severe disabilities the option of pursuing employment possibilities.

The initial intent of Title VII was to meet the needs of those persons with severe disabilities not yet ready for vocational rehabilitation services. Part A, when implemented will enable this laudable goal to be addressed.

As testimony was presented to your committee on March 21, I was struck by the high degree of inter-relatedeness of all parts of the Rehabilitation Act. Each part of the Act is vital to the whole.

We know you are faced with difficult financial choices; we also know that reduction in funding in any section or title of the Act will have deleterious effects on all parts.

We hope that our views and the other views which you will receive, support our conclusion that the public investment in the programs in the Rehabilitation Act deserves an increased public investment across all titles of the Act.

Once again, thank you for your dedication and deep commitment to the concern of persons with disabilities.

Yours truly,

Marvin O Spears
Marvin O. Spears
President

NATIONAL REHABILITATION ASSOCIATION

THE NAVAJO NATION
WINDOW ROCK, NAVAJO NATION (ARIZONA) 86515

PETERSON ZAH
CHAIRMAN, NAVAJO TRIBAL COUNCIL

EDWARD T. BEGAY
VICE CHAIRMAN, NAVAJO TRIBAL COUNCIL

March 30, 1983

The Honorable Carl D. Perkins
U. S. House of Representatives
Washington, D. C. 20515

Dear Congressional Delegate:

Enclosed please find a written testimonial by the Navajo Tribe addressing the recommended considerations for amendments to Public Law 95-602, the 1978 amendments to the Rehabilitation Act. This testimony specifically addresses Title I, Part D, Section 130, Rehabilitation Services to American Indians.

We hope that you can lend your support and advocacy to the serious consideration and implementation of these recommendations. We are confident that your concern is for appropriate vocational rehabilitation services to all disabled people, and in particular, to disabled American Indians.

We, as American Indians, will be ever grateful and appreciative of your support of the recommendations and concerns outlined in this testimony. For further information, contact Mr. Elmer J. Guy, Director of the Navajo Vocational Rehabilitation Program, P. O. Box 1420, Navajo Tribe, Window Rock, Arizona 86515, (602) 871-5076.

Respectfully,

David J. Tsosie

David J. Tsosie, Chairman
Education Committee
Navajo Tribal Council

Enclosures

/mth

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TESTIMONY BY THE NAVAJO TRIBE FOR AMERICAN INDIAN REHABILITATION SERVICES

Until the recent past, services to rehabilitate disabled people were administered totally by the states and the Federal Government with little or no regard for the special needs of handicapped Native Americans. The experiences of disabled American Indians with these services have demonstrated the inadequacy of state rehabilitation services to meet their needs. Disabled Navajo clients have been closed out for "failure to cooperate", "no contacts" or "unsuccessful" for when they had not responded to written communication because they could not read, had not returned calls because they had no telephones, they had no transportation to attend appointments, etc. Rehabilitation is a numbers game and in order to claim successful closures among Navajos, state vocational rehabilitation (V.R.) counselors would close them out as "successful" sheepherders.

In the mid-1960s the Navajo people themselves took the initiative to intervene on behalf of their disabled clansmen. They challenged the inefficient, unfair, and unrealistic practices of State VR Programs. These deficiences included:

1. Lack of adequate and appropriate counselor orientation to the culture and heritage of Navajo clients - office providing statewide VR services were, for the most part located in large metropolitan areas within the state. Counselors in these cities were familiar only with the circumstances of clients who had ready access to such conveniences as telephone, public transportation systems, timely delivery of mail, industries and support services. Navajo clients living in remote areas, hundreds of miles away from from these counselors and many miles away from paved roads were expected to respond and comply with the same system being implemented in the cities. These state counselors made infrequent visits to the homes of Navajo clients and were heavily dependent upon written communication. Many Navajo VR clients, however, could not read or write. In the event of a home visit, counselors could not communicate effectively with clients because of the language barrier. Interpreters were often of minimal help and, some cases, created greater problems through misinterpretations. Delivery of mail to Navajo families was, and in some instances still is sporadic, untimely, undependable and communal (i.e. it's delivered to the trading post and families pick it up when they come in for supplies). Telephones, were and are few and far between and clients have had no access to local public transportation.

2. Limited Services - State VR Programs had no pro-

visions, or active plans to recruit Counselor who were familiar with the Navajo people and their language, life styles and locale. As stated before State VR offices were not located in proximity to Navajo clients. In addition, State VR Counselors were often selective in the clientele they would serve. Severely disabled Navajo clients were often placed as low priority. Their cases were too often dismissed with the explantion: "too severely disabled", "unwilling to relocate", "failure to cooperate", etc... State VR Services will primarily focused in cities and border towns.

3. Irrelevant Goals - Goals and objectives which were set by State VR Programs often took into consideration only urban settings with their conveniences and industrialization. No consideration was given to rural isolated Indian communities, their culture, or their economy.

4. Lack of cross-governmental coordination - The Navajo reservation and its population extend into three states (Arizona, New Mexico, Utah) and three federal regions (VII, VIII, IX). Each governmental unit claimed jurisdiction and responsibility over only a portion of the reservation. There was little, if any, interstate and interregion coordination. The Navajo people were impelled to contend with three different state programs, as well as their own tribal government and the Bureau of Indian Affairs.

5. Native Healing Services - State VR Programs had no provisions to incorporate the use of Native healing services into the rehabilitation process of disabled Navajos. The use of such services by Navajos is an essential aspect of their lives and plays a vital role in their treatment of disabilities. Disallow- of the use of Native Healing Services by traditional rehabilitation systems represented disrespect to Navajo people and Navajo clients and actually impeded the rehabilitation process in many cases.

This situation changed in 1978. In that year an amendment to the Rehabilitation Act of 1973 (P.L. 93-112) added Section 130. Section 130 specifically addresses the rehabilitation of American Indians. It contains provisions for earmarking funds of up to 1% of the overall rehabilitation allotment to support the Indian Tribal vocational rehabilitation programs. Funds were not available under this provision until fiscal year 1981.

In the immediate years preceding receipt of federal vocational rehabilitation dollars by the Navajo Tribe, The Tribe undertook the coordination and consolidation of VR services for the Navajo people. This was the beginning of cross-governmental coordination for the provision of appropriate VR services to disabled Navajo clients. The Navajo Vocational Rehabilitation Program has been the sole project funded under Section 130 of P. L. 95-602. It has had an annual appropriation minimally of $650,000, an amount which impacts only a portion of the needs. This project, administered by Navajos with a staff which is over 90% Navajo, has made measurable progress towards the delivery of appropriate VR services to its clientele. The program serves over five hundred (500) disabled Navajos annually. Navajo clients have found employment in welding, clerical work, pastor, computer operator, etc... The Program now has rehabilitation workers who are familiar with the local economy, the language, the culture and habitat of the people. The program is making the local government aware of the employment needs and desires of disabled Navajos. Local employers are becoming sensitized to the potential of this work force.

The Navajo Vocational Rehabilitation Program was established in 1975. It has been in operation for eight years. The program has grown much during this time:

1. Beginning as a State VR sub-office, it now operates as an autonomous program.

2. Beginning with a staff of five, the program is now staffed by nineteen dedicated and qualified individuals.

3. Beginning as a small seemingly insignificant subcomponent program within the Navajo Division of Education it has now attained branch status within the Division with a total staff of over thirty in four handicapped service related programs.

4. Beginning with a caseload of less than 75 the program now maintains a caseload of over 400 active files.

Viewing these accomplishments, the Navajo Tribe feels that it has proven its capability for administering a VR program to serve its disabled citizens. The Navajo Tribe feels that the Navajo Vocational Rehabilitation Program should receive recognition commensurate to its proven abilities and be granted secure funding, comparable to state and trust territory programs. Such funding can be justified based upon area served, population served, program uniqueness, governmental status, and federal responsibility to Indian Tribes. The Navajo Tribe seeks your support in attaining status comparable to a state or trust territory under Title I of the Rehabilitation Act. There are trust territories of the United States of America which are afforded this status. Some of these trust territories have a population less than that of the Navajo Nation (160,000), occupy a geographical area less than that of the Navajo Nation (25,000 square miles), and yet receive a greater funding allocation.

In addition, we are seeking this status in order to make the funding of specific VR services to Navajo people more secure. Under Section 130, we have been required annually to secure a special congressional appropriation for our program under Section 130. It was the understanding of the Navajo Tribe from reading Section 130 that upon receipt of federal dollars to the Navajo Vocational Rehabilitation Program, states formally providing VR services to the Navajo Nation would cut back in those services and in funds requested for those services one-third each year, giving total VR responsibility to the Navajo Vocational Rehabilitation Program in the third year. The States have followed this procedure in case management, but not in fiscal matters. They are still receiving formula allocations based upon the inclusions of the Navajo disabled population. We are still receiving "special project" funding with year-to-year funding under Section 130, and with the withdrawal of VR services by states, the Navajo Vocational Rehabilitation Program fears for the lack of long-term provision of VR services to Navajo people. We are soliciting the support of this subcommittee for the continuance and stabilization of funding for the Navajo Vocational Rehabilitation Program through appropriate legislation.

The need remains for appropriations under Section 130 of P.L. 95-602 to support innovative initiatives for the provision of appropriate and relevant VR services to American Indians. Should the recognition of the Navajo Vocational Rehabilitation Program as a State Status Program not receive favorable action, there is a need to increase funding appropriations under Section 130 to meet the expansion of the Navajo Vocational Rehabilitation Program as well as the possible development of VR programs among other Indian Tribes. Failure to increase appropriations under Section 130 will result in intense competition by Indian groups for minimal allocations and/or reduced services as more programs are added.

There is an additional need to assure and guarantee continual fiscal support of successful VR programs for American Indians. Many man hours are devoted annually to securing appropriations under Section 130. This time could be better spent serving our clients. We hope you will assist us in securing the legislation necessary to give our program the legal support and financial support it needs to continue.

Thank you.

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FACT SHEET FOR NAVAJO TRIBE'S TESTIMONY

CURRENT CASE STATUS
August 1982 - March 1983

AGENCY:	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	14	16	18	20	22	24	26	28	30
Chinle	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5	1	4	1	1	5	0	7	6
Crownpoint	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	4	0	1	0	0	1	0	0	1
Ft. Defiance	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2	0	6	1	3	0	2	6	0
Shiprock	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	5	0	4	0	2	0	2	3	0
Tuba City	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	4	1	14	1	3	3	11	4	2
Blind Clients	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	1	0	0	0	0	0	0
TOTAL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	20	2	30	3	9	9	15	20	9

SD: Severely Disabled

Non-SD: Non-Severely Disabled

SUCCESSFUL REHABILITATION CLOSURES IN SEVEN MONTH PERIOD
(August 1982 - March 1983)

JOB TITLE:

Sheltered employment	Pastor
Stock Boy	Dishwasher
Drafting Assistance	Truck Operator
Fiberglass Modular	Clerk Typist
Computer Operator	Construction Carpenter Aide
Maintenance Man	Residential Aide
Alcoholism Guidance Counselor	Welder
Fashion Clerk	Assistant Manager
Para-Legal Advocate	

Number of clients awaiting VR services: Sixty-three (63)

E. NAVAJO NATION STATUS SYSTEM:

Navajo Vocational Rehabilitation Program Status. Provision for native healing services include as authorize by Public Law 95-602, Title I, Part D, Section 130, 1362.45 "Projects for American Indian Vocational Rehabilitation Services."

Status 00. REFERRAL This is the date client is first brought to the attention of Vocational Rehabilitation.

STATUS 02. APPLICANT A referred individual becomes an applicant when the applicantion document requesting vocational rehabilitation services is signed. Native healing service diagnostic provision.

STATUS 06. EXTENDED EVALUATION An applicant is placed in extended evaluation if counselor certifies: 1) the presence of a handicap to employment, and 2) an inability to make a determination that services might benefit the client unless there is an extended evaluation to determine rehabilitation potential. A case may remain in status 06 no longer than 18 months. Native healing service provision.

STATUS 08. CASE CLOSED FROM REFERRAL, APPLICANT OR EXTENDED EVALUATION A case is closed in status 08 if client does not meet the basic eligibility requirements to be accepted into status 10.

STATUS 10. IWRP DEVELOPMENT After establishing the presence of an employment handicap and the reasonable expectation services will benefit the client in terms of employability, a case is placed in status 10 while case study and diagnostic are completed to provide the basis of a rehabilitation program.

STATUS 12. IWRP READY FOR IMPLEMENTATION A case is placed in status 12 when the rehabilitation program is written and approved and until such time as at least one service has been initiated.

STATUS 14. COUNSELING AND GUIDANCE ONLY Under a rehabilitation program, counseling and guidance by the Vocational Rehabilitation Counselor and placement are the only services which may be provided in this status.

STATUS 16. PHYSICAL AND MENTAL RESTORATION A case is placed in status 16 at the time restoration services are initiated. Training may be provided simultaneously with restoration in status 16 if the restoration service is expected to run for the longer period of time. Native healing service provision.

STATUS 18. TRAINING The case is placed in status 18 when training services are initiated. Restoration services may be provided simultaneously with training in status 18 if the training is expected to run for the longer period of time.

STATUS 20. READY FOR EMPLOYMENT The case is placed in status 20 when the rehabilitation program has been completed or terminated and client is ready to accept employment.

STATUS 22. IN EMPLOYMENT The case is placed in status 22 when client actually begins employment.

STATUS 24. SERVICE INTERRUPTED The case is placed in status 24 when services are interruped in statuses 14, 16, 18, 20 or 22. The case remains in status 24 until client returns to one of these statuses or case is closed.

STATUS 26. CLOSED REHABILITATED Case is closed status 26 when client has been provided all appropriate services, the rehabilitation program has been completed insofar as possible, and client has been suitably employed for a minimum of 60 days.

STATUS 28. CLOSED NOT REHABILITATED AFTER PROGRAM INITIATED A case is closed status 28 if at least one service was provided (status 14, 16 or 18) but client is unable to continue the program.

STATUS 30. CLOSED NOT REHABILITATED BEFORE PROGRAM INITIATED A case is closed status 30 if client was accepted for services (status 10 or 12) but was unable to actually begin a rehabilitation program.

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national
easter seal society
60 YEARS OF SERVICE TO HANDICAPPED PEOPLE

Office of Governmental Affairs

March 30, 1983

The Honorable Austin J. Murphy
Chairman
House Subcommittee on
  Select Education
Room 617, House Annex #1
Washington, D. C. 20515

Dear Mr. Chairman:

The National Easter Seal Society appreciates the opportunity to contribute to the evaluation and improvement of the programs under the Rehabilitation Act. As the nation's oldest and largest voluntary health agency, Easter Seals has actively participated in the growth and development of the rehabilitation movement. The National Society believes that the reauthorization process provides an excellent opportunity to assess once again the effectiveness of Rehabilitation Act programs and services. In addition, it provides an occasion for the many federal, state, local and private rehabilitation agencies to reaffirm their commitment to providing quality services to persons with disabilities.

Historically, Easter Seal involvement in the provision of rehabilitation services to the public predates the federal role in this area. Easter Seals was founded in Ohio in 1919, in order to provide rehabilitation services to children with disabilities. A year later, the federal government established its first non-military rehabilitation program under the National Civilian Vocational Rehabilitation Act (also known as the Smith-Fess Act).

In the more than sixty years that have elapsed, the Easter Seal Society has expanded in size and scope of services. The National Easter Seal Society currently represents 827 state and local societies. These societies offer a wide range of rehabilitation, health care and related services to both children and adults. In 1982, Easter Seals served over 759,000 individuals. Many of these people were served under programs authorized by the Rehabilitation Act. It is through this level of involvement and through our role as an advocate for persons with disabilities that the National Society has developed the views expressed in this statement.

As written, the Rehabilitation Act embodies one of the most comprehensive and effective systems of providing human services. The National Society wholly supports the Rehabilitation Act and urges Congress to extend authorization for a period of five years. It is our belief that the programs authorized under the

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Rehabilitation Act represent a broad and balanced approach to meeting the rehabilitation needs of persons with disabilities. We encourage Congress to retain all of the programs provided for under the Act, regardless of their funding status. Each of these programs and the services they provide represents a unique and vital aspect of the overall rehabilitation process.

Easter Seal Proposals

This statement reflects the concerns of the National Society and the organizations it represents relative to programs under the Rehabilitation Act. For the most part, these concerns focus on the ability of nonprofit rehabilitation centers to participate effectively in the vocational and related rehabilitation programs in the Act. These programs represent one of the largest, most comprehensive sources of rehabilitation services available to people with disabilities. We believe, therefore, that every effort should be made to improve the Rehabilitation Act as written and as administered.

The National Society has identified several provisions in the Act which require either amendment, report language or simply the attention of Congress. These include the "work center" definition, support services for rehabilitation facilities, the federal role relative to Rehabilitation Act programs and the need for recreation services. The National Society urges Congress to examine these areas during reauthorization and, in so doing, consider Easter Seals' recommendations. We also ask that Congress consider the testimony prepared by the Consortium for Citizens with Developmental Disabilities, which was submitted on behalf of Easter Seals and thirteen other organizations.

The New "Work Center" Terminology

The National Society proposes that the Rehabilitation Act be amended to include the definition of the term "work center". This term describes those vocational rehabilitation facilities formerly referred to as "sheltered workshops". It is our belief that the old, familiar "workshop" label no longer projects an acceptable, and in some cases, accurate image of today's vocational rehabilitation facilities. This amendment, therefore, is intended to establish the "work center" term in the Act to more clearly define the positive and productive nature of these vocational rehabilitation facilities.

In an effort to reflect the positive development of vocational rehabilitation facilities in the Rehabilitation Act, the National Society proposes that the "work center" term be added. This can be accomplished by adding the "work center" definition as Section 7(16), which would read as follows:

> The term "work center" means a rehabilitation facility, or that part of a rehabilitation facility, engaged in production or service operation for the primary purpose of providing employment as an interim step in the rehabilitation process or as an extended work opportunity for those invididuals who cannot be readily absorbed in the competitive labor market.

The National Society proposes that the term "work center" be substituted for the term "workshop" wherever it is used in the Act. The adoption of the term "work center" provides needed recognition for the substantial changes that have occurred in vocational rehabilitation facilities. During the past several years, such facilities have initiated new and innovative work programs. These programs have greatly expanded the vocational rehabilitation process and, as a result, have increased the opportunities available to individuals with disabilities. In addition, new types of personnel have been employed by these facilities to achieve a range of skills more comparable to those found in competitive employment. The new "work center" terminology sends a signal to the community that a definite and positive transition has taken place within those facilities known as "sheltered workshops".

A major benefit of the "work center" amendment is the incentive which the new terminology provides to vocational rehabilitation facilities to reassess their roles in the community. Consideration of the "work center" concept by facilities will bring about a review of organizational goals and structure. For many facilities, the adoption of the "work center" identity will be accompanied by a revised sense of mission and an improved vocational rehabilitation program.

In this regard, the adoption of the "work center" designation by a facility represents an important step in its organizational evolution. The transition of a "workshop" to a "work center" demonstrates to the community an effort on the part of the facility to redefine its purpose. This transition can be viewed as a means by which the facility signals its intention to become more businesslike. In effect, the new name upgrades the image of the facility to a more productive, work-oriented center for rehabilitation. This new image can be used to promote greater involvement of employers and, consequently, will lead to an increase in the number of contracts and improved placement of persons with disabilities in the competitive labor market. The National Society believes that adoption of the "work center" identity represents much more than a superficial substitution of terms. It represents a timely and significant opportunity in the development of vocational rehabilitation facilities.

Support for Rehabilitation Facilities

Rehabilitation facilities are a critical component in the provision of services to individuals with disabilities. Although these facilities vary in size, range of services and sophistication, they are all devoted to providing high quality, cost-effective rehabilitation services. For many persons with disabilities, the local rehabiliation facility represents much more than a service provider. The facility and its staff represent a vital source of assistance through which personal fulfillment, independence and vocational goals can be achieved.

The Rehabilitation Act has placed considerable emphasis on the utilization of rehabilitation facilities. Under Title I, rehabilitation facilities provide the means for evaluating, treating and training persons with disabilities. In fact, a significant percentage of the funds expended by state vocational rehabilitation agencies each year is spent on services to individuals in rehabilitation facilities. In 1979, rehabilitation facilities provided services to 185,000 or 20% of all state vocational rehabilitation clients. That year, the services provided by rehabilitation facilities to vocational rehabilitation clients represented 33.9% of the total state agency budget.

Although some rehabilitation facilities are operated by state and local governments, the majority are operated by voluntary agencies. Approximately 30% of the vocational rehabilitation services financed annually by state agencies are delivered in nonprofit rehabilitation facilities. In addition, these facilities are often the site of a vast array of support services, including recreation, transportation and independent living.

Given the substantial role of nonprofit rehabilitation facilities in the provision of vocational and related rehabilitation services, the National Society believes that the federal government has a strong interest in the continued success of these facilities. In terms of the quantity and quality of services provided by nonprofit rehabilitation facilities, the federal stake is considerable. For this reason, the National Society proposes that federal support for nonprofit rehabilitation facilities under the Rehabilitation Act be proportionate to the level of services provided by these facilities under the Act.

Currently, there are a number of provisions contained in the Rehabilitation Act (funded and unfunded) which provide support for nonprofit rehabilitation facilities. These include programs for facility construction, loan guarantees and federal improvement grants, rehabilitation training and rehabilitation research. The National Society believes that federal financial assistance for facility construction and improvement is a cost-effective means of assuring the future presence of nonprofit facilities in the national rehabilitation effort. Similarly, the level of investment in facility-oriented rehabilitation training and research has a direct impact on the personnel and technology available to rehabilitation facilities. Furthermore, provisions exist under the Act to provide technical assistance to nonprofit rehabilitation facilities. These provisions must be restructured in order to restore the level of assistance to nonprofit rehabilitation facilities originally intended by Congress.

As written, the Rehabilitation Act provides ample evidence of a federal commitment to the construction and periodic improvement of nonprofit rehabilitation facilities. Under Title III, Sections 301, 302 and 303 of the Act, provisions were established which would make funding available to build, equip and staff rehabilitation facilities, assist in the financing of facilities through federal loan guarantees, and assess and improve facility services and staff. Unfortunately, the provision regarding loan guarantees has never been funded and the construction and improvement grant programs have not received funding in recent years. It should be noted, however, that when such monies were available, these programs proved very effective.

The lack of federal finanical support at this time is especially damaging. Many rehabilitation facilities are in critical need of repair and modernization. Built decades ago, these facilities need an infusion of funds in order to retain their effectiveness as competent providers of rehabilitation services. In addition, population shifts have created a strong demand for rehabilitation services in many areas of the south and southwest. Many communities are ill-equipped to meet these needs. Similarly, the emphasis on deinstitutionalization has greatly increased the demand for outpatient rehabilitation services. The combined effect of these trends and the aging of existing rehabilitation facilities makes the need for federal support clear.

The National Society urges Congress to recognize the need for a strong federal role in the construction and improvement of nonprofit rehabilitation facilities. Despite an authority to spend as much as ten percent of their rehabilitation budget on construction, states have not demonstrated a willingness to acknowledge this area of need. Furthermore, present economic conditions make it much more difficult for nonprofit facilities to raise independently the needed monies. Unless Congress reaffirms an interest in these programs, the share of rehabilitation services provided by nonprofit facilities could soon be jeopardized.

A similar challenge has developed in the fields of rehabilitation training and rehabilitation research. Under the Act, the Rehabilitation Training program was established to ensure that skilled rehabilitation professionals would be available to meet the needs of persons with disabilities. Similarly, the National Institute of Handicapped Research was created in order to promote research and technological advancement in areas of importance to people with disabilities. Unfortunately, as these programs have evolved, the resources devoted to facility-oriented fields diminished. This has occurred despite language within the Act which specifically addresses the needs of nonprofit rehabilitation facilities.

As an advocate for individuals with disabilities and a major provider of rehabilitation services, Easter Seals believes that facility-related training and research projects should be established in each of these national programs. Again, the large-scale involvement of nonprofit facilities in the field of rehabilitation demands that greater emphasis be placed on facility needs within training and research. Easter Seal facilities are often forced to operate with reduced staff, due to the shortage of trained rehabilitation personnel. The need for pre-service and in-service training for nonprofit facility staff is glaring. Furthermore, the National Society and many other nonprofit agencies support valuable research activities in the area of rehabilitation. However, a commitment is required at the national level to see that the unique aspects of the facility environment are considered. The National Society urges Congress to restate the importance of facility-oriented training and research activities under the Act. The amount of resources devoted to rehabilitation training and, to a lesser degree, research might well be linked to the level of rehabilitation services provided by facilities. This would guarantee that facility-specific needs are given adequate attention and, as a result, provide a reliable source of skilled personnel and the benefits of research.

Another important concern of rehabilitation facility administrators is the need for technical assistance under the Rehabilitation Act. Nonprofit rehabilitation facilities are continually searching for new ideas and alternatives to enhance the quality and delivery of services. In the past, federal technical assistance proved invaluable to nonprofit facilities. Under the Act, RSA coordinated the matching of consultants to the needs of specific rehabilitation facilities. These expert consultants provided technical assistance on a wide range of topics, including accounting, contract procurement, safety, work evaluation, engineering and program services. In addition to the benefits realized by facilities in implementing the consultants' recommendations, the use of "internal" experts provided a substantial cost-savings with respect to purchasing consultation services. At an estimated average cost of $500 per consultation, this federally-sponsored assistance cost considerably less than comparable assistance purchased in the marketplace.

Unfortunately, the provision which enabled this technical assistance for nonprofit rehabilitation facilities was greatly weakened as a result of the 1978 amendments. In 1973, technical assistance was extended to nonprofit organizations other than rehabilitation facilities, but only for advice on the elimination of architectural and transportation barriers. In an effort to expand this provision, the authority regarding technical assistance was revised to make rehabilitation facilities and other nonprofit agencies eligible for full federal technical assistance. However, this change led to a condensation of the language in the Act. As a result, the Office of General Counsel interpreted the new wording to mean that technical assistance was available only for barrier removal both for facilities and other nonprofit agencies. Authority for the provision was moved from Title III, Section 304(e)(1) to Title V, Section 506, of the Act. Following this change, technical assistance to rehabilitation facilities continued through 1981 under Section 12 of the Act. No general assistance or assistance regarding barrier removal has been provided to rehabilitation or other nonprofit agencies under Section 506 since the authority was revised.

The National Society believes that federal technical assistance is critical to the successful operation of nonprofit rehabilitation facilities. Consequently, the National Society proposes that the authority for technical assistance to nonprofit rehabilitation facilities and other organizations be restored to Title III of the Act. This can be accomplished by rewording Section 506(1) of Title V to read: "The Secretary shall provide by contract with experts or consultants or groups thereof, technical assistance —

A) to rehabilitation facilities; and

B) to any public or nonprofit agency, institution, organization, or facility."

The language in Sections 506(2) and (4) need not be changed. The revised provision, comprised of Sections (1), (2) and (4), should be moved to Part A under Title III.

The National Easter Seal Society believes that this amendment will effectively restore the authority for facility-directed technical assistance. In addition to the direct benefits, such as better fiscal management and improved marketing and program services, the consultations introduce a diverse group of technical specialists to the rehabilitation environment. It is our belief that the revitalization of federal technical assistance to nonprofit rehabilitation facilities is a necessary and cost-efficient means of helping such facilities effectively meet the needs of persons with disabilities.

At the same time, the intent of the 1978 amendments should not be lost. Although assistance regarding the removal of architectural, transportation and communications barriers has never materialized under Section 506, a definite need for such targeted assistance exists. Nonprofit rehabilitation facilities and other agencies have demonstrated an eagerness to remove barriers confronting persons with disabilities. However, the funding allocated to the Architectural and Transportation Barriers Compliance Board to provide technical assistance in this area severely limits the amount of assistance available. The National Society urges Congress to adopt report language during reauthorization which strengthens the Board's role in providing technical assistance to nonprofit rehabilitation facilities. Such language should also instruct the Board to cooperate with facility representatives and Rehabilitation Services Administration personnel to identify the specific needs of facilities relative to the removal of barriers. Moreover, report language should expand these efforts to include facility-oriented barrier research and technological development.

Lastly, the formula of reimbursement for services provided to vocational rehabilitation clients by nonprofit rehabilitation agencies is a point of contention. The National Society would like to go on record in opposition to the use of charitable contributions as an offset to reimbursement for services provided by rehabilitation facilities. As noted earlier, the state vocational rehabilitation agencies rely heavily on nonprofit facilities to provide a broad range of rehabilitation services. What wasn't noted, however, was the degree of control exercised by state agencies over such facilities through determination of reimbursement amounts. Reimbursement is generally made through the payment of fees which are negotiated with nonprofit facilities. The fees ordinarily reflect salaries, depreciation of the building and equipment, supplies, utilities and other operating expenses. Unfortunately, certain state agencies have, in the past, elected to consider the unrestricted charitable donations of a facility as an offset to reduce the reimbursement amount. This practice acts as a disincentive to facilities to raise funds within their communities. Such donations are extremely important to many facilities and contribute significantly to the scope and quality of the services they provide. Moreover, contributed income often compensates the facility for rehabilitation services that are not reimburseable or are provided to persons unable to pay for them. At a time when the Administration is advocating the maximum use of private sector resources, the offset of charitable contributions by state agencies is conspicuously inconsistent.

The National Society urges Congress to amend the Act to prohibit the offset of charitable contributions in the formula used to determine reimbursement for rehabilitation facility services. These facilities are entitled to adequate payment for the rehabilitation services they provide. We believe that guidelines to this effect, at the federal level, will ensure that rehabilitation facilities across the nation receive reimbursement commensurate with costs.

The Federal Role

As an advocate for people with disabilities, the National Society is very concerned about the role of the federal government relative to programs under the Rehabilitation Act. Traditionally, federal involvement in service programs administered by states has been meant to ensure that the intent of Congress is met, that the program is administered uniformly across states, and that innovative projects are funded in order to demonstrate new methods, services and technologies. The National Society believes that this active federal role is advantageous and appropriate for the effective provision of quality rehabilitation services.

Recently, however, there has been a noticeable decline in the level of federal participation in Rehabilitation Act programs. For this reason, the National Society proposes that Congress use the reauthorization process to review the federal role regarding programs under the Act. Our statement focuses on several issues relevant to federal involvement, including the collection and analysis of program data and the use of resulting statistics to evaluate program effectiveness.

For the past sixty-three years, state and federal agencies, rehabilitation facilities and others have cooperated in the provision of vocational and related rehabilitation services. Under Title I, the vocational rehabilitation program has clearly demonstrated the success of the state-federal partnership in providing needed services to persons with disabilities. In an effort to maintain an ongoing assessment of the success and substance of these services, the Rehabilitation Services Administration (RSA) collects a wide range of program information. This information is analyzed and delivered to Congress on an annual basis. The Congress uses this information in its oversight activities. In addition, RSA disseminates the results of these assessments to all state vocational rehabilitation agencies. State administrators rely on the statistics prepared by RSA to compare individual program performance to that of other states. Through comparison, state agencies can identify programs in need of improvement and take steps to bring them in line with similar programs in other states. Furthermore, RSA uses these statistics to regulate the delivery of vocational rehabilitation services and administer efficiently this substantial human service program.

The National Society believes that current and accurate statistics are fundamental to every facet of program administration. Reliable statistics contribute much to the skillful administration and delivery of vocational rehabilitation services. Unfortunately, the collection and analysis of program data has been significantly reduced in recent years. In the interest of lessening the burden of federal paperwork requirements, RSA has been instructed to limit its data processing activities. Much of the data that was previously collected and analyzed with respect to the services delivered under Title I, is no longer being gathered by RSA.

The National Society recognizes the intent of the regulatory reform efforts, but we believe that accurate program statistics are invaluable to the effective administration of the vocational rehabilitation program. It is our understanding that the familiar reporting form R-300 has been replaced by a shorter form, the 911. Under the 911, data regarding the client's family and the amount of public monies received at application to the program and at closure will no longer be required. This represents a loss of information that has traditionally provided a better understanding of the client's background and a measure of the program's impact with respect to the client's reliance on public assistance. In addition, state agencies have been given the option of reporting 911 data on a sample basis. Fortunately, few states are expected to exercise this option, as essentially all of the information required by the 911 is collected by states for their own use. Although considerably abridged, the National Society believes that the 911 form is an effective data collection instrument. However, we also believe that it represents the absolute minimum amount of information that should be collected in the evaluation of the vocational rehabilitation program.

The National Society certainly supports efforts directed at reducing the burden of paperwork required by the federal government. However, the limitation on RSA to collect needed program information does not seem to be in the best interest of the program. The statistics formerly collected by RSA are, for the most part, still collected by state vocational rehabilitation agencies. These statistics are basic to the administration of the vocational rehabilitation program at the state level. It would follow that they are of equal importance at the federal level.

In addition, the revision of reporting forms to lessen paperwork requirements has, in some cases, meant that simple procedures to insure accuracy have been eliminated. For example, RSA has been directed by the Office of Management and Budget (OMB) to refrain from collecting certain derivative data. What this means is that, on some forms, states are not required to provide totals for columns of figures reported to RSA. As a result, RSA staff are often required to seek verification for much of the data, so as to avoid the use of figures which may have been incorrectly recorded on the form. Consequently, a quick and simple calculation at the state level has been traded for the expense of follow-up calls and the greater risk that inaccurate program information will go undetected.

Under the Act, the Secretary is directed to report annually to Congress on the effectiveness of the vocational rehabilitation program. It would be extremely unfortunate if the efforts aimed at deregulation were to erode the data base available to Congress for meaningful oversight. The National Society urges Congress to consider carefully the information currently available regarding the programs under Title I of the Rehabilitation Act. A detailed review of the data collected and analyzed relative to the provision of vocational rehabilitation services should be conducted, so that the statistics needed by Congress are readily available. In addition, the National Society urges Congress to include in its review an evaluation of the role of the Office of Management and Budget (OMB) in the operation of Title I programs. During the past few years, OMB has actively pursued the deregulation of these programs. In particular, OMB has targeted the information collected by RSA from state agencies in its efforts to reduce burdensome paperwork. The National Society lauds these activities in that they eliminate the reporting requirements no longer of benefit to the rehabilitation process. However, it is our belief that the extent of the burden can best be determined by the state vocational rehabilitation agencies themselves. Once program participants have identified data reporting elements that are no longer of value, it would seem appropriate to involve OMB in the process of revising forms and data collection procedures.

The National Society proposes that the Act be amended to include a provision which directs that the RSA-SSA Data Link be maintained. The RSA-SSA Data Link is a useful tool for the assessment of the impact of vocational rehabilitation on the lives of persons with disabilities. In November, 1982, RSA released a report summarizing the Data Link study results. The report, entitled "The Long Term Impact of Vocational Rehabilitation, By Severity of Disability", revealed that:

> 1) The post-closure earnings and employment experience of disabled persons rehabilitated in the State-Federal program of vocational rehabilitation was found to be superior to that of persons who could not be rehabilitated. The study applies to the period ranging from the year before referral, 1973 on the average, to the third year after case closure, 1977.
>
> 2) The failure to be rehabilitated had a much harsher enconomic impact on severely disabled persons than on those who were not severely disabled in terms of employment and earnings in the three years after case closure.

The same report provided the earnings per dollar of expenditure and an earnings summary record for severely disabled and non-severely disabled individuals.

The information obtained from this cooperative effort between RSA and the Social Security Administration provides a valuable measure of the impact of rehabilitation on the employment and earnings of persons with disabilities. Unfortunately, no Data Link data beyond calendar year 1977 are available. The National Society believes that the RSA-SSA Data Link should be established on a long-term basis, so that similar reports can be periodically produced. We propose that the Rehabilitation Act be amended to require that, at a minimum, an assessment of the employment and earnings status of the 1975 cohort be completed every three years. Moreover, it is our belief that new groups should be established every five years and monitored at three year intervals thereafter. The information supplied by this interagency study represents one of the few sources of post-closure feedback on the impact of vocational rehabilitation. The National Society urges Congress to amend the Act to require that the RSA-SSA Data Link be continued and that the funds and personnel needed for this unique and valuable study be provided under the Act.

The justification for the collection and data analysis activities under Title I is equally applicable to all other Rehabilitation Act programs. Each year, millions of dollars are dispersed under the Act for the provision of rehabilitation and related services to persons with disabilities. In order to insure that the decisions regarding these programs are made in an informed manner, the ongoing collection and analysis of program information is needed. The National Society believes that accurate and up-to-date statistics at the federal level are a prerequisite to effective program administration. For this reason, Congress is urged to develop report language which emphasizes the value of evaluation to the success of the rehabilitation movement. Under Section 14 of the Act, the Secretary is directed to evaluate all Rehabilitation Act programs. The National Society supports the comprehensive evaluation efforts authorized under Section 14. We encourage Congress to include report language which strengthens the nonpolitical role of these evaluation efforts.

Lastly, within the context of the federal role, the National Society would like to call attention to a concern that has been raised relative to the location of rehabilitation agencies within state governments. During the past year, Easter Seal staff has interviewed a wide range of rehabilitation professionals. One of the concerns expressed by rehabilitation counselors and others in the vocational rehabilitation system was the potential for the erosion of program effectiveness due to a loss of direct control over program resources. It was reported that state agencies located in large "umbrella" departments of the state bureaucracy were often more subject to external fiscal and operational constraints. The fear was expressed that agencies so situated were sometimes required to allocate funds for overhead costs and other indirect expenses not necessarily related to the provision of vocational rehabilitation services. Similar constraints were also said to affect the management of personnel within the state agency.

The National Society is not in a position to thoroughly evaluate these concerns. However, it seems in the best interest of the program that as much responsibility as possible remain with the state vocational rehabilitation agency regarding the allocation of financial and personnel resources. Under the Act, states are provided with detailed instructions as to the organizational responsibility, level and status of vocational rehabilitation agencies. Moreover, the intent of this statutory language has been tested and validated on several occasions, as in the U. S. District Court of the Northern District of Florida ruling. The National Society believes that state vocational rehabilitation agencies should have organizational unit status within the hierarchy of state government and urges Congress to evaluate this issue during reauthorization.

Recreation Services

One of the more important aspects of federal involvement in programs under the Rehabilitation Act is the support provided for innovative projects and services that might not otherwise be established. This function is particularly true of the federal role relative to the provision of recreation services to individuals with disabilities. Easter Seals has taken an active interest in the development of recreation programs to serve children and adults with disabilities. In fact, during 1982, Easter Seal societies provided recreational services to over 40,000 individuals in a variety of settings, including resident camps, day camps and structured recreation programs. Our direct experience with the provision of recreation services has served to reinforce our commitment to this important, but often overlooked aspect of the rehabilitation process.

Under Title III, Section 316 of the Act, grants are made to states and other public and nonprofit agencies to pay part or all of the cost of establishing recreation programs to aid in the mobility and socialization of persons with disabilities. The role of recreation in rehabilitation is an important one. Recreation and rehabilitation professionals maintain that there is a therapeutic value to participation in recreation programs and that recreational activities are an essential element of a balanced lifestyle. Programs established under Section 316 encompass a broad range of activities, including sports, music, dance, arts and crafts and camping. Provisions under the Act specify that existing resources be used whenever possible, thereby discouraging the development of new facilities and encouraging the integration of persons with disabilities into established community recreation programs.

The National Society urges Congress to develop report language which identifies the provision of recreation services as a priority under the Act. In order to bring about the balance of services under the Act as intended, it is necessary to emphasize the full compliment of rehabilitation services, including recreation. The National Society believes that the recreation programs established under Section 316 represent the quickest and most cost-efficient way to make recreational opportunities available to persons with disabilities.

New Federalism

The National Easter Seal Society would like to go on record as opposed to the Administration's proposal to turn the vocational rehabilitation program back to the states. This proposal would include the vocational rehabilitation program among the thirty-four programs slated to be "turned back" to the states during the period of 1984 through 1988. It is our belief that this action is not in the best interest of the vocational rehabilitation program or the people it is meant to serve.

The intent of the turnback proposal is to give states greater flexibility in the administration of the vocational rehabilitation program. Experience has shown, however, that this state-federal partnership has traditionally allowed states a great deal of discretion in providing rehabilitation services. The National Society believes that there is a definite need to maintain a strong federal presence in the vocational rehabilitation program. At a minimum, the federal government is responsible for overseeing the use of the millions of dollars it invests each year in the program. More importantly, the federal role is intrinsic to effective program administration and the assurance that quality vocational rehabilitation services are available to persons with disabilities. For these reasons, the National Society urges Congress to resist any efforts to further transfer the responsibility for the vocational rehabilitation program to the state level.

The National Easter Seal Society appreciates this opportunity to comment on programs under the Rehabilitation Act during reauthorization. We hope that the Subcommittee will find our recommendations useful.

Sincerely,

Joseph D. Romer

Joseph D. Romer
Director of Governmental Affairs

Randall L. Rutta

Randall L. Rutta
Legislative Analyst

AMERICAN FOUNDATION FOR THE BLIND, INC

[illegible]

STATEMENT OF IRVIN P. SCHLOSS, DIRECTOR OF GOVERNMENTAL RELATIONS, AMERICAN FOUNDATION FOR THE BLIND, TO THE SUBCOMMITTEE ON SELECT EDUCATION, COMMITTEE ON EDUCATION AND LABOR, HOUSE OF REPRESENTATIVES, ON PROPOSALS TO EXTEND AND IMPROVE THE REHABILITATION ACT OF 1973

March 30, 1983

Mr. Chairman and members of the Subcommittee, I am pleased to have this opportunity to present the views of the American Foundation for the Blind, the national voluntary research and consultant agency in the field of services to blind persons of all ages, on proposals to extend and improve the Rehabilitation Act of 1973.

The American Foundation for the Blind endorses enactment of the following recommendations designed to strengthen the Rehabilitation Act of 1973:

1. Permanent extension of the program of basic state grants and extension of all other programs under the Act through September 30, 1986, with increases in the authorizations of appropriations.
2. Modification of the program of Independent Living Services for Older Blind Individuals under Section 721 of the Act.

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so that it will have its own authorizations of appropriations.

3. Establishment of an independent client advocacy project in each state with separate authorizations of appropriations and advocacy responsibility for all Federally financed activities useful to handicapped persons.
4. Establishment of the Helen Keller National Center for Death-Blind Youths and Adults as a special institution.
5. Accreditation of local voluntary agencies serving handicapped persons as a prerequisite for grants or contracts by state rehabilitation agencies.

Extension of the Rehabilitation Act of 1973

The American Foundation for the Blind recommends extending the authorizations of appropriations for basic state grants on a permanent basis and extension of other programs under the Act through September 30, 1986. For implementation of the basic vocational rehabilitation program under Section 110 of the Act, we recommend authorizations of appropriations of $1.040 billion for FY 1984, $1.145 billion for FY 1985, $1.255 billion for FY 1986, $1.380 billion for FY 1987, and increases in subsequent fiscal years based on increases in the Consumer Price Index. As a result of high inflation rates and virtually level funding for basic grants in recent years, fewer handicapped persons have been rehabilitated for gainful employment, thereby increasing their dependence on the Supplemental Security Income (SSI) program under Title XVI of the Social Security

Act. By increasing authorizations for basic state grants and by subsequent indexing in accordance with increases in the Consumer Price Index, reduction in essential rehabilitation services to handicapped individuals would be prevented.

Rehabilitation Services for Older Blind Persons

One of the major gaps in services to blind persons in the United States continues to be lack of provision of adequate rehabilitation services for middle-aged and older blind persons. According to the National Society for the Prevention of Blindness, three-fourths of the legally blind population is 40 years of age and older; and three-fourths of all new blindness occurs in the same age group. The National Center for Health Statistics of the U.S. Public Health Service reports that 1,185,000 of the estimated 1.4 million people in this country with severe visual impairment are 45 and older.

Rehabilitation programs tend to concentrate on blind and visually impaired individuals of optimum employable age and serve very few middle-aged and older blind persons. Yet with appropriate training in mobility and other techniques of doing things without sight, middle-aged and older individuals can frequently be assisted to retain their jobs--jobs in which they have had many years of experience. Others may require vocational retraining as well and can take advantage of old skills and extensive work experience to train for a new job, given the proper vocational rehabilitation assistance. The important thing is that age should not be regarded as a barrier to vocational rehabilitation of blind and visually handicapped persons.

Prior to the 1978 amendments to the Act, a small program of special projects in the rehabilitation of older blind persons was implemented in a few states.

A Rehabilitation Services Administration report on one of those projects states "...Two of the more important but frightening findings of this project are: (1) overwhelming need for the special services provided under this type program demonstrated by the number of referrals made to the project during its initial three year period, and which continues to be demonstrated during the fourth year; and (2) prior to the start of the project, no public or private agency existed that provided the manpower or funds to deliver these special services nor to even identify and locate this special target population..."

For the projects in operation during fiscal year 1977, some 1,850 individuals were referred for services; 1,650 received services; and 400 were closed from the projects as rehabilitated.

The 1978 amendments added Independent Living Services for Older Blind Individuals as Part C of Title VII of the Act, with the authorizations of appropriations limited to 10 percent of the funds appropriated for Part A of that title. Since Part A, which provides for grants to the states for comprehensive independent living services, has not been funded through the appropriations process, the program of services for older blind persons has not received any funding. In view of the success of the special projects for older blind persons in effect prior to the 1978 amendments in providing both independent living and vocational rehabilitation services, we strongly urge a separate authorization of appropriations to implement Part C of Title VII.

Client Advocacy Projects

At present, client assistance projects under Section 112 of the Act are in effect in 38 states at an estimated cost of $1.7 million for fiscal year 1983. We believe that this program should be expanded over the next three years to cover all states and that the program should have a specific authorization of appropriations.

As a result of the impact of Section 504 and the provisions prohibiting discrimination against handicapped persons in the State and Local Fiscal Assistance Amendments of 1976, there is a great need for technical assistance on matters affecting the civil rights of the disabled. The expanded client assistance program we recommend could play an important role in integrating the handicapped into society. This role should not be limited to advocacy of client rights under programs authorized by the Rehabilitation Act of 1973. It should also cover Federal assistance programs which may materially help handicapped individuals, such as higher education, social services, health care, and income maintenance.

To reflect the expanded role of the client assistance projects, we recommend that they be renamed "client advocacy projects," with specific authorizations of appropriations of $3.5 million for the fiscal year 1984, $4 million for the fiscal year 1985, and $5 million for fiscal year 1986. This will allow for orderly expansion in a program which is demonstrating that it is of substantial help to handicapped persons and their families. This expanded program should be administered through the state vocational rehabilitation agencies with assurances of maximum independence for the client advocates.

Helen Keller National Center

The Helen Keller National Center for Deaf-Blind Youths and Adults and its affiliated network provide services to individuals with one of the most severe forms of disability. These services are designed to help deaf-blind persons become "self-sufficient, independent and employable."

The authorization for the services of the Center to deaf-blind persons, as well as training of highly specialized personnel and research and demonstration projects, is currently provided under Section 313 of the Rehabilitation Act of 1973. The American Foundation for the Blind believes that adequate funding for the increasing number of deaf-blind persons now reaching adulthood as well as older blind persons who also lose hearing would best be accomplished by authorizing the Secretary of Education to include the Helen Keller National Center as a special institution in the annual budget of the Department of Education. Therefore, we recommend repeal of Section 313 of the Rehabilitation Act of 1973 and enactment in its place of the provisions of H.R. 1810.

Accreditation of Local Voluntary Agencies

The American Foundation for the Blind firmly believes that the key to effective rehabilitation services for handicapped persons is assurance of high standards through an accreditation mechanism. Therefore, we urge amendments to the Rehabilitation Act of 1973 to require state vocational rehabilitation agencies and state agencies serving blind persons to contract for rehabilitation services to clients with local voluntary agencies and rehabilitation facilities accredited by an accrediting agency recognized by the Department of Education. For example, the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC) is recognized by the Eligibility and Agency Evaluation Section of the Department of Education as a standard-setting and accrediting body for the field of special schools for the blind and visually handicapped. NAC has also developed standards and accredited various agencies serving blind persons, including those which operate rehabilitation facilities. We recommend that the role of the Eligibility and Agency Evaluation Section be expanded to include recognition of accrediting bodies for rehabilitation services.

Conclusion

In conclusion, Mr. Chairman, the American Foundation for the Blind endorses permanent extension of the program of basic state grants under the Rehabilitation Act of 1973, as well as extension of the other programs under the Act through September 30, 1986. In addition, we urge that the target program of Independent Living for Older Blind Individuals under Part C of Title VII of the Act be given its own authorization of appropriations. We also urge creation of an extensive and meaningful client advocacy program; accreditation of voluntary agencies with which state agencies contract for services to handicapped persons; and establishment of the Helen Keller National Center for Deaf-Blind Youth and Adults as a special institution in the Department of Education.

We believe that our recommendations will greatly improve services to handicapped persons under the Rehabilitation Act of 1973 and urge your favorable consideration.

PREPARED STATEMENT OF RADM DAVID M. COONEY, USN (RET.), PRESIDENT AND CHIEF EXECUTIVE OFFICER, GOODWILL INDUSTRIES OF AMERICA, INC.

Goodwill Industries of America welcomes the opportunity to comment on the proposed reauthorization of the Rehabilitation Act. Continued authorization of the Act is of vital concern and importance to disabled citizens and to the purposes and operations of Goodwill Industries. Goodwill Industries is a nonprofit membership organization of 177 rehabilitation facilities in North America with 44 affiliates in 31 countries outside of North America. As such, we are the largest network of privately operated, vocational rehabilitation workshops in the world. Currently, Goodwill Industries provides rehabilitation services to 67,700 disabled people and employs almost 33,000 disabled clients in our production facilities, retail outlets and industrial contract programs. Goodwill Industries provide a wide variety of rehabilitation services, including vocational evaluation, job training, employment, adjustment services, job seeking skills, and placement. Thus, we feel particularly involved and qualified to comment on proposed changes to the Act.

Since its enactment in 1973, the Act has been successful in serving the needs of disabled citizens and the Rehabilitation Services Administration has administered various provisions of the current law effectively. We believe that reauthorization of the Act, for a minimum of three years, is of primary and fundamental importance and we wholeheartedly support that action. The rehabilitation program has been a successful partnership between the federal government, state agencies, and the non profit rehabilitation community. It should be extended to give both the states and rehabilitation agencies an insurance of continuity and the time to plan ahead.

Of the previous testimony submitted by various organizations involved with the Act, we would like to state for the record, that we basically concur with and support the opinions and positions expressed by the National Association of Rehabilitation Facilities. Additionally, we support the recommendations offered by the Consortium for Citizens With Developmental Disabilities, especially as they relate to proposed authorization levels and implementation of various provisions of the Act. Because of this support, we do not intend to burden the record by reiterating the various points raised by both these organizations.

What we do not support are certain positions, as we understand them, by the Department of Education before the Senate Subcommittee on the Handicapped and the House Subcommittee on Select Education.

First, we strongly oppose the proposal to finance the Rehabilitation Services program in a block grant to the states. It is our view, clearly stated in the past, that block grants have no role in addressing the problems of America's handicapped population. Under the Administration's proposal for a New Federalism block grant, there would be no requirement that the states spend any money on rehabilitation services after five years. We believe that only a national program administered to meet national needs will ensure that uniform standards and an equitable distribution of resources are enforced in each state.

It is a fact of life that the allocation of block grant funds within a state will be strongly influenced by local political pressures. In most cases that is proper in a democracy. Nevertheless, although America's handicapped citizens constitute its largest social minority, they are not now organized as a political action group nor because of current social attitudes have they been encouraged to so organize, nor because of their handicaps are they able to organize and speak for themselves on many issues. It is thus fitting and proper that their interests be addressed by an knowledgeable and prestigious body in the federal establishment and that their viewpoints be received and considered by Congressional committees like this one in order to provide reasonably attainable national standards of rehabilitation. The proper role of the federal government is to make the tough choices and exercise oversight. Without that national role for rehabilitation services, the quality and availability of these services would vary too widely between the states, to the detriment of handicapped individuals and the general population. Therefore, we recommend that the proposal for block granting be immediately disregarded as counter-productive.

The full intent of the Department of Education becomes clear when block grant funding of the rehabilitation program is combined with Section 5 of their proposed bill, which removes many of the State plan provisions and eliminates the requirements for certain minimum services. These two proposals in combination reveal a long term intent to abolish a federal rehabilitation services program. We find this totally unacceptable and detrimental to all citizens.

Secondly, the Administration's proposal to establish a system of rewards to those states who have been able to achieve higher levels of rehabilitation similarly disregards the needs of disabled individuals and penalizes states for circumstances over which they may have no control. For example, such a system would penalize those states with high unemployment rates regardless of their success in rehabilitating severely disabled individuals. As a case in point, in the State of Michigan, unemployment in some communities has been as high as 20%. Despite that fact, rehabilitation agencies in the state have continued active vocational rehabilitation programs and have been successful in equipping individuals to enter the job market when the economy improves. The fact that they did not become immediately employed is not an indication of any ineffectiveness of the Michigan State Director of Vocational Rehabilitation or of the management of local rehabilitation facilities. It is rather an indication of the fact that there is unemployment in the State of Michigan and that unemployment impacts on handicapped people as well as the able bodied. To punish the State of Michigan, already in serious economic difficulty, for a situation not of their creation, is poor economics and poor social practice. There are other states and regions with similar problems familiar to the committee, Michigan is merely a clear example.

Unemployment is not the only potential cause of such anomalies. Social structure of communities, the impact of weather, the onset of pregnancy, seasonable variables in employment rates are but a few of the economic and social variables which make the proposal unworkable and probably counter-productive. Additionally, to be fair, the system proposed by the Administration would require a standardized system of measurement applied universally by an agency other than the state itself. The requirement for the creation of such a bureaucracy would consume resources needlessly.

Thirdly, we oppose the Administration's proposals to include programs under Title III of the Act in a single authorization and to delete authorizations for currently unfunded authorities. Specifically, we feel there should be reauthorization and funding for Innovation and Expansion Grants and for Facility Construction Grants.

While opposing the Department of Education's proposals, Goodwill Industries finds itself hindered in making affirmative, substantative recommendations for what we believe are necessary changes in the current law because of an overriding problem with the Act. The Act as presently written and implemented does not provide for meaningful feedback concerning the effectiveness of delivery of rehabilitation services. There is a paucity of any reliable, standardized data on which to evaluate the effectiveness of the Act over the past ten years. We question the figures that the Rehabilitation Services Administration has set forth in its testimony, since our inquires to RSA have only gained responses based on data as much as three years old. There is no information available concerning the utilization rate or cost savings realized from the use of private non profit facilities for the delivery of rehabilitation services. Requests for data concerning the number of clients processed and the cost for delivery of services to these clients have been unsuccessful. Additionally, the state directors of vocational rehabilitation have either been reluctant or unable to provide such information to private organizations, such as Goodwill even when our purposes parallel their own.

We do know from our own in-house audits that certain trends are developing which are of concern. The number of clients being referred to nonprofit facilities is declining and the states' share of costs of servicing the clients has also been reduced. In some states, sponsored clients have virtually disappeared and in others, Goodwills no longer seek state sponsored clients because of unrealistic compensation levels for work performed or extensive bureaucratic burdens. In some cases, the Goodwill accepts total responsibility for the client as a less expensive and more efficient technique of meeting community needs than becoming involved with the state program.

Our experience with the various states on how they are administering their programs has also varied widely. In some states, the state bureaucracy's have grown without any seeming increase in service to clients, while in other states they have been able to reduce their administrative overhead and increase service by referring more clients to private facilities. Moreover, there has been no uniformity or consistency on how the states determine their cost of services and fees. This experience of the past several years causes Goodwill Industries to make certain recommendations for changes in the Act. Clearly these recommendations are in need of further refinement. However, we believe that it is not in the best interest of the disabled citizens simply to reauthorize the Act, without the inclusion of these measures.

First, there needs to be more specific inclusion in the Act for more detailed data collection, especially as it relates to administrative costs. Provisions need to be made to mandate that RSA collect data on the utilization of all service providers, including private nonprofit facilities, and their effectiveness in delivering services to clients. The Secretary's annual report and evaluation of the Act's program, required by Sections 13 and 14 of the Act, should specify that such reports and evaluations include comparisons between public and private facilities. Similar requirements should be included in the state's recordkeeping requirements and studies and reviews, specified by Sections 101 (a)(10), (15) and (16) of the Act. Only in this way will it be possible to evaluate fully the effectiveness of the states in delivering rehabilitation services to handicapped individuals. The review of expenditures to rehabilitation outcomes would be the basis for determining how future rehabilitation dollars are effectively and efficiently spent.

Secondly, more emphasis needs to be placed on providing funding, under Title I of the Act, for the provision of direct services to clients. This could be accomplished by amending the Act to mandate that a set percentage of Basic State Grants to be spent on direct rehabilitative services and that a concurrent limitation be set on allowable administrative costs. Such a provision would increase the accountability of state agencies and provide a reasonable measure of uniformity in the distribution of rehabilitation services between states.

The limited and dated information, currently available, reveals wide variations between the states on administrative expenses. A limited in-house Goodwill Industries survey that one state's expenditure of funds for administrative purposes was as low as 9% whereas another state's administrative expenditures was 59%. A study conducted by the National Association of Rehabilitation Facilities, based on 1978 data, shows that states averaged 44% of their administrative expenditures on administration and counseling as opposed to case services. In one of the states, the administrative expenses were as high as 70%. Clearly, these inadequate statistics standing alone may be meaningless, for the raw figures do not reveal what items are included in administrative expenses nor do they necessarily indicate how effective a state is in delivering services to clients. However, what they do reveal is that there is currently no adequate way to measure whether funds are properly being administered to provide direct services to clients.

Before a limit could be set on the amount that states could expend for administrative purposes, it would be necessary to define exactly what constitutes administrative expenses. Once such a definition is developed, a statutory limitation on administrative expenditures would provide an uniform means for measuring states' effectiveness in delivering services and help guarantee that the basic purposes of the Act are being fulfilled.

Thirdly, Goodwill Industries believes that more disabled clients can be served, at less cost to the government, if the Act is amended to encourage greater utilization by the states of private nonprofit facilities. Goodwill's experience demonstrates that private facilities can be highly successful in providing rehabilitative services at limited cost to the government. Currently, on a national average basis, for every dollar expended by Goodwill facilities on rehabilitation services, $.03 is earned from sources other than the states' fees.

This actually means that Goodwill subsidizes state and Federal programs. In 1982 Goodwill's contribution to the national rehabilitation effort was approximately $225 million. This figure represents income and services provided to or for disabled individuals. Of this amount, $187 million was earned from sources other than State VR fees for services. Thus, Goodwill's contribution equals approximately 25% of the total federal expenditures in the Basic State Grants program in 1982. This sort of investment entitles us to a partner's voice in establishing program objectives and costs.

Greater utilization of community-based private organizations would not only keep costs down through reasonable competition, but would provide an incentive to create private nonprofit facilities where no rehabilitation facilities presently exist. The result would be broader-based care that would not require handicapped individuals to travel significant distances to receive that care.

In conjunction with this recommendation, we urge that any consideration of the Administration's proposal to allow grants to for-profit organizations be modified to provide that such grants be given to for-profit organizations only when state or nonprofit agencies are not available and where the purpose is to provide geographical coverage where none is available. Such a modification is not contradictory with the philosophy of encouraging private sector utilization. Where nonprofit agencies exist they can keep costs down, but to do so they need broad-based community support. If that support is decreased by federal grants or subsidies to for-profit agencies, which then perform work previously accomplished by the nonprofit agency, unit costs will increase in the nonprofit agency and overhead will become burdensome. This could have an overall negative effect on the costs of service delivery, dictating a reduction in client loads.

We urge that Sections 101 (a)(5) and (12) of the current Act should be amended to require that states place a priority on utilizing, to the maximum extent possible, private facilities for rehabilitation services when they are reasonably available at competitive costs. Funding for the states should be contingent on satisfactory demonstration to the Commissioner that they adhere to these provisions. This type of provision, in conjunction with the above recommendation concerning data collection on utilization on private sector facilities, would provide the basis for long term evaluation on the effectiveness of delivery systems.

In summary, Goodwill urges the Congress to reauthorize the Rehabilitation Act with the inclusion of the three recommendations stated above and the positions taken by the National Association of Rehabilitation Facilities and the Consortium for Citizens With Developmental Disabilities. Such action would ensure that the Rehabilitation Act becomes an even more effective vehicle for serving the needs of disabled Americans. We appreciate the opportunity to submit this statement and look forward to working with the Committee on implementing necessary changes. For the Committee's consideration, we are attaching to this statement a copy of a resolution passed by the Board of Directors of Goodwill Industries of America, Inc., which sets forth our basic recommendations.

GOODWILL INDUSTRIES OF AMERICA, INC.

BOARD OF DIRECTORS

March 19, 1983

It was moved, seconded and carried that the Board adopt the following resolution:

WHEREAS, the Rehabilitation Act of 1973, as amended, is pending reauthorization before the 98th Congress, and

WHEREAS, the Rehabilitation Act has proven its effectiveness in assisting people with disabilities and the reauthorization provides an opportunity to recommend certain structural changes to the Act that will result in the provision of more efficient and direct services to disabled individuals, and

WHEREAS, insufficient data is currently available to provide effective oversight, implementation, and enforcement of the program authorized by the Act,

THEREFORE, BE IT RESOLVED by the Board of Directors of Goodwill Industries of America, Inc., to support the reauthorization of the Act with changes that will set a limitation on administrative expenses, increase the utilization of private rehabilitation facilities when available, and increase the reporting of data by the Rehabilitation Services Administration.

Prepared Statement of Roger P. Kingsley, Ph. D., Director, Congressional Relations Division, Governmental Affairs Department, the American Speech-Language-Hearing Association

The American Speech-Language-Hearing Association (ASHA) welcomes the opportunity to present its views and recommendations concerning rehabilitation programs serving citizens with handicapping conditions. Physically and mentally handicapped persons comprise a substantial portion of the nation's population - around 35 million people. Among the most prevalent handicapping conditions are speech, language, and hearing impairments. Because the ability to communicate effectively is so fundamental to other life activities - learning, interpersonal relationships, and vocational pursuits - any loss or limitation of this ability can be detrimental to individual human development and performance.

ASHA is the professional and scientific society representing over 37,000 speech-language pathologists and audiologists nationwide, including many who provide rehabilitation services to handicapped adults. Our members work in hospitals, speech and hearing clinics, outpatient rehabilitation centers, skilled nursing facilities, home health agencies, Head Start programs, Veterans Administration and Department of Defense hospitals, public and private schools, and independent practice.

The Rehabilitation Act is widely judged to be one of the most significant and successful statutes relating to human services and human rights. Broad in scope, this one Act provides America's handicapped citizens with the promise of fulfilling their life's potential through basic rehabilitation services, assistance from quality trained professionals, opportunities for independent living, and guarantees of basic rights. We support each of these sections of the Act: the Vocational Rehabilitation State Grant Program, Rehabilitation

Training, Comprehensive Services for Independent Living, Projects With Industry, the National Institute for Handicapped Research, the National Council on the Handicapped, and Title V, particularly a strongly enforced Section 504 prohibiting discrimination against qualified handicapped persons in all programs and activities receiving federal financial assistance.

This statement will briefly examine several of these sections and will provide ASHA's recommendations for authorization levels for each of the major programs in the Rehabilitation Act of 1973 (P.L. 93-112), as amended by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978 (P.L. 95-602). Then we will focus in more depth on two areas which we believe have weakened the effectiveness of the Act's implementation and are in need of congressional review and legislative reform: the "balanced" program of Rehabilitation Training assistance and the Office of Deafness and Communicative Disorders.

Basic Rehabilitation State Grants (Section 110)

The Vocational Rehabilitation State Grant program has been a model of working federalism - an effective federal state partnership - for sixty-two years. Since 1921, the program has served about 23 million persons and has rehabilitated more than six million of them. The cost-effectiveness of the program is very high (a ratio of better than 1 to 10) and it is estimated that the benefit to governments at all levels is about $280 million, including income and payroll taxes and funding saved as a result of decreased dependency on public welfare and institutional care.[1]

About one million handicapped individuals are served annually, although the number has been declining for the past six years since funding has not kept pace with inflation and because a larger proportion of severely (and hard to rehabilitate) persons are being served. The number of persons successfully rehabilitated and the number of new cases have also been declining.

This year we have an opportunity to reverse these trends and to enable more handicapped citizens to benefit from vocational rehabilitation services. This Association recommends that Congress raise the authorization levels for Basic State Grants to $1,037.8 million for FY 1984; $1,141.1 million for FY 1985; and $1,254.6 million for FY 1986.

Rehabilitation Training (Section 304)

The Rehabilitation Training program was established by Congress in 1954 to provide for the preparation and maintenance of a qualified rehabilitation work force. The program was expanded in 1973 to meet the demand for more specialized personnel qualified to work with persons suffering from a variety of disabling conditions and to improve the skills of those already engaged in rehabilitation of the handicapped. The program supports training in the broad range of established rehabilitation fields identified in the Rehabilitation Act including speech-language pathology, audiology, physical therapy, occupational therapy, rehabilitation counseling, and interpreters for the deaf.

Despite the need for greater numbers of rehabilitation professionals to serve the handicapped and despite serious shortages of adequately trained professionals in many fields, federal support for this program has been declining since fiscal year 1980. We recommend that the authorization level for Rehabilitation Training be set at $30.5 million for fiscal years 1984 through 1986.

We also favor amending Section 304 to clarify the responsibility of RSA in allocating training funds. The term "balanced" program has no clear meaning and should either be defined or eliminated. Either way, Congress should require the Commissioner to submit to Congress, along with the RSA budget proposal, a detailed explanation of how funds will be allocated among the rehabilitation disciplines and how these allocations are related to legitimate findings of personnel shortages.

National Institute of Handicapped Research

The National Institute of Handicapped Research was established by the 1978 rehabilitation amendments (P.L. 95-602) "to promote and coordinate research with respect to handicapped individuals..." (Sec. 202(a)).

According to the NIHR, research funds in fiscal 1982 were provided to centers conducting long-term studies and utilizing teams of medical, allied health and technical health professionals. Core areas of research have included comprehensive rehabilitation, vocational rehabilitation, aging, mental illness, deafness and hearing impairment, sensory and communicative systems, and blindness. The Institute has provided support for important work in the development of communication aids, and through its grants has recognized the importance of research into the special problems of the elderly disabled population.

Innovative research is essential to the overall effectiveness of the rehabilitation program. Yet, funding for NIHR has lagged for several years. We recommend that authorization levels be established at $35 milliou for FY 1984 and $40 million for fiscal years 1985 and 1986.

National Council on the Handicapped

The Rehabilitation Act Amendments of 1978 established a National Council on the Handicapped. The Council is responsible for establishing general policies for NIHR and for advising the Commissioner of RSA and the Assistant Secretary for Special Education and Rehabilitative Services (OSERS) with respect to policies relating to the Rehabilitation Act of 1973, as amended. Membership on the Council has included handicapped individuals, community leaders, and experts in the disability field.

Recently, the work of the Council has been hampered by insufficient resources and staff. We believe that the Council has an important leadership and coordinating role in rehabilitation of the handicapped policies and should be continued and strengthened. We recommend that the authorization ceiling of $256,000 be retained for fiscal years 1984-1986.

Rehabilitation Training: Unbalanced

Legislative Requirements

As in any professional service area, vocational rehabilitation services are only as good as the personnel who provide them. Personnel who specialize in the rehabilitation of handicapped individuals must receive quality training and must be trained in numbers adequate to ensure accessibility for persons in regions throughout the country and with a variety of disabling conditions. Congress has recognized these needs by making rehabilitation training an integral part of the overall federal-state vocational rehabilitation program. Authorization is provided for states and public or nonprofit agencies and organizations, including institutions of higher education, to fund projects to increase the number of personnel trained in providing vocational and social rehabilitation services to handicapped individuals. Section 304(b) of the Rehabilitation Act of 1973, as amended, states that

> In making such grants or contracts, funds made available for any year will be utilized to provide a balanced program of assistance to meet the medical, vocational, and other personnel training needs of both public and private rehabilitation programs and institutions, to include projects in rehabilitation medicine, rehabilitation nursing, rehabilitation counseling, rehabilitation social work, rehabilitation psychiatry, rehabilitation psychology, physical therapy, occupational therapy, speech pathology and audiology, workshop and facility administration, prosthetics and orthotics, specialized personnel in providing services to blind and deaf individuals, specialized personnel in providing job development and job placement services for handicapped individuals, recreation for ill and handicapped individuals, and other fields contributing to the rehabilitation of handicapped individuals, including homebound and institutionalized individuals and handicapped individuals with limited English-speaking ability. (emphasis added)

Despite the congressional mandate for a "balanced" program, the Rehabilitation Services Administration has consistently reduced the number of trainng projects in speech-language pathology and audiology (see Appendix A). As recently as FY 1979, 50 projects were funded with expenditures of $1,351,000. Three years later, in FY 1982, only 17 projects were funded with $405,359. This represents a 70 percent decline which is explained only in part by the overall reduction in Rehabilitation Training funds (37 percent). Similar reductions in training support are evident in other disciplines, such as physical and occupational therapy. (see Appendix B).

The statute does not explicitly define "balanced program," thus leaving considerable discretion to RSA. Training priorities are often established more on the basis of political and budgetary factors than the actual need for different kinds of rehabilitation services. Several years ago, a report concerning the impact of rehabilitation training support on the service delivery system found that "RSA does not use data on the characteristics of existing rehabilitation personnel for planning purposes."[2] The report concluded that "there has been no way to systematically estimate the demand for rehabilitation personnel in many of the established disciplines other than by contacting professional organizations." However, in recent years, RSA has shown no interest in receiving or utilizing information on training needs from this professional association.

Funding for Rehabilitation Training this year is at the same level as in FY 1982 - $19.2 million. Despite this, we have recently learned from RSA officials that no new training grants will be awarded to speech-language pathology and audiology programs this year. What was supposed to be a "balanced" program of assistance for rehabilitation training has obviously become seriously unbalanced.

Rehabilitation Service Needs: the Communicatively Handicapped

In its most recent Annual Report to the President and Congress, the Rehabilitation Services Administration states that training grants are authorized by the Rehabilitation Act of 1973, as amended, to ensure that skilled personnel "are available to provide the broad scope of vocational rehabilitation services needed by severely handicapped individuals served by vocational rehabilitation agencies and rehabilitation facilities."[4] There are several points to be made about this statement. The first is that, although the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978 (P.L. 95-602) placed greater emphasis on the rehabilitation of severely handicapped adults, it did not eliminate the less-severely handicapped from inclusion in the program.

> The purpose of this Act is to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living. (Section 2 of the Rehabilitation Act of 1973, as amended)

And, the purpose of Title III - Supplementary Services and Facilities - includes the authorizing of grants and contracts

> to assist in the provision of vocational training services to handicapped individuals. (Section 200(2))

As defined in the Act, the term "handicapped individual" means any individual who

> (i) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (ii) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services...(Section 7(7)(A) of the Rehabilitation Act of 1973, as amended)

This Association believes that it would be bad policy and a misinterpretation of congressional intent to target rehabilitation services exclusively to the severely handicapped. Yet, in recent testimony before the Senate Subcommittee on the Handicapped, a Department of Education official stated that the Administration's Rehabilitation Act revisions are designed to direct resources away from individuals who are "marginally handicapped."

This leads to a second point: although all handicapped individuals are potentially eligible to receive rehabilitation services, an important criterion is the capacity to benefit from such services. In this context, it it is important to note that persons with moderate and severe communication disorders can often be rehabilitated to a degree that enables them to function effectively in day-to-day activities. The ability to communicate is a necessary skill in almost all walks of life. The importance of adequate communication ability in interpersonal relationship, educational and vocational pursuits is undeniable. Based on current population estimates, approximately 22.6 million Americans suffer from speech, language, and hearing impairments, making communication disorders the nation's most prevalent category of handicapping conditions.[5] It has been estimated that among adults ages 18 to 79, seven to eight percent suffer from some degree of hearing loss. The annual deficit in earning power among the hearing handicapped is estimated at over one and one-quarter billion dollars.[6]

Due to non-identification and underreporting of speech and language impairments in the U.S. population, prevalence of these disorders is uncertain. However, it is generally assumed that at least 10 million individuals, including children and adults, suffer from speech and language impairments.

As a result of congenital impairments, accidents, and severe illness, the number of persons with speech, language and hearing disorders is constantly growing. As the communicatively handicapped population increases, so does the demand for well-trained speech-language pathologists and audiologists to serve in rehabilitation settings.

Most speech and language disorders can be corrected when appropriate diagnoses and treatments are available and are provided. Although hearing loss is usually irreversible, many hard-of-hearing (as opposed to deaf) individuals can also be helped through professional rehabilitation and the use of hearing aids. Because the ability to communicate effectively is so important in the work environment and because communicative disorders have such a high potential for successful rehabilitation, programs designed and funded to serve this population are very cost-effective.

RSA reports that in fiscal year 1981, 255,881 individuals were rehabilitated through the federal-state program. Yet, despite the significant potential for rehabilitation, relatively few persons with speech, language and hearing impairments have been served. Only 20,300 of the individuals rehabilitated in 1981 had communication disorders, including 7,700 deaf, 10,800 hard-of-hearing, and 1,800 with speech and language impairments.[8] Over one and one-half million Americans are prevented from working as a result of communication disorders, and among the estimated 16.5 million people with a partial work disability are one million who suffer from speech, language and hearing impairments.[9]

A final point here is that communication impairments are often related to severe handicapping conditions like Parkinsonism, cerebral palsy, and multiple sclerosis. Individual rehabilitation programs for persons with these neurological conditions frequently include the services of speech, language and hearing professionals. About one in five stroke patients have communication problems and need specialized rehabilitation in order to regain the use of their speech and language mechanisms.

Training Needs: Speech-Language Pathology and Audiology

In a 1979 report prepared by the HEW-HRA Bureau of Health Manpower for the Senate Committee on Labor and Human Resources and the House Committee on Interstate and Foreign Commerce (now Energy and Commerce), serious shortages were found in the availability of speech-language pathologists and audiologists. (See Appendixes C and D). Using conservative estimates of prevalence of communication disorders and data from a National Institutes of Health study, the Bureau concluded that "at least three or four times more speech pathologists are needed and approximately four times as many audiologists are needed to provide required services...it appears that the supply of speech pathologists and audiologists is not adequate to meet either current or future demands and needs."[10]

Although the extent and location of these shortages is not known, there is clearly no contrary evidence that warrants RSA's dissolving of future training funds in the field of speech-langauge pathology and audiology. Quite the opposite - the large and ever-increasing population of persons with primary and secondary communication disorders requires the on-going training of professionals who will be available to meet their rehabilitation needs. A "balanced" program of assistance would certainly seem to imply this, and we ask this Committee to reemphasize the importance of an adequate supply of quality trained professionals in the various rehabilitation disciplines and to require that RSA base its allocation of training funds on actual need.

The Deafness and Communicative Disorders Program

Finally, ASHA wishes to bring to the attention of this Subcommittee a little noticed but highly significant report concerning the federal role in the rehabilitation of adults with communication handicaps.

The Rehabilitation Services Administration is the federal agency responsible for providing leadership and coordination of rehabilitation programs for adult Americans. As such, RSA is responsible for planning, developing, implementing and evaluating rehabilitation programs for communicatively handicapped persons. The Deafness and Communicative Disorders Office (DCDO) is the unit within RSA charged with these tasks. However, this office has historically lacked the authority and the resources necessary to provide adequate representation of the rehabilitation needs of over 20 million Americans with speech, language and hearing disorders.

There are several problems related to the weak record of DCDO. Unlike administrative strutures for the blind and visually impaired and the developmentally disabled population, the program for the deaf and communicatively impaired has no legal base. The former programs are situated in the Office of Program Operations while DCDO is located in the Office of Advocacy and

Coordination. DCDO exists only by administrative authority and receives no direct appropriations. As the Task Force Report on the Deafness and Communicative Disorders Program states, "Of all the programs dedicated to persons with specific disabilities, the program for the communicatively impaired is the most susceptible to the precariously changing currents in the American political stream. It already gets too little funding when economic and political conditions are good, but it gets even less when times are bad."[11]

Another problem is that DCDO has focused most of its meager resources on a small minority of the overall population that it is supposed to serve. Of the more than 16 million hearing impaired people in the United States, only about 2 million are totally deaf.[12] The vast majority are hard-of-hearing, speech and/or language impaired. Deafness is certainly one of the most serious handicapping conditions, and we support continuing federal and state efforts to assist in the special education and vocational rehabilitation of this group. However, while many deaf persons have been underserved, most speech, language and hard-of-hearing persons have been unserved. As an illustration of this imbalance, DCDO personnel have spent only about 13 percent of their time on activities directed at the needs of the non-deaf communicatively impaired population.[13]

These problems must eventually be addressed through Congressional action. The DCDO should be given statutory authority and placed in the RSA Office of Program Operations. In the meantime, however, there is much that could be done administratively to improve the effectiveness of this program and to better address the rehabilitation needs of communicatively impaired

Americans. The Commissioner of RSA has the authority to provide a larger measure of resources for the program. We would also hope that the Commissioner would support the effort to secure a legal base for the DCDO. The Task Force Report sets forth a detailed plan for establishing a comprehensive and effective program to provide better leadership and services for the rehabilitative needs of citizens with communication disorders. To our knowledge, no steps have been taken to implement this plan since the Report was presented to RSA over three years ago. We believe that it is time for the Administration to start taking this Report seriously. We have provided a copy of this Report to the Subcommittee staff and hope that the Congress will work toward implementing its objectives over the next several years.

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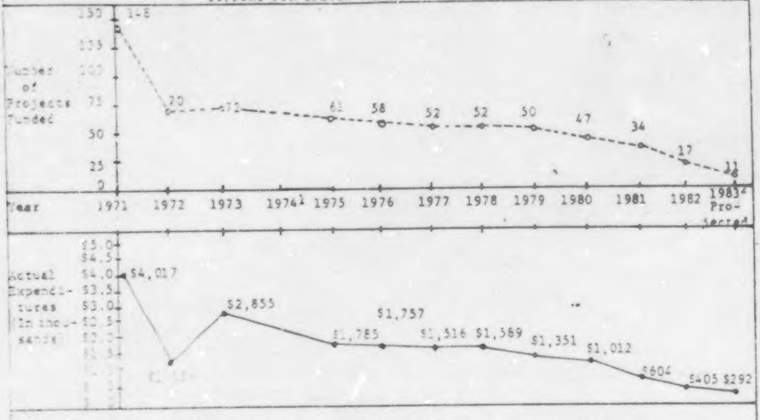
1. Rehabilitation Services Administration,, Office of Special Education and Rehabilitative Services, Annual Report to the President and the Congress on Federal Activities Related to the Administration of the Rehabilitation Act of 1973 as amended (Fiscal Year 1981), i-ii.
2. JWK International Corporation, "An Assessment of the Impact of Rehabilitation Training Grant Support in Selected Areas of Academic and Non-Academic Training on Improving the Effectiveness of the Vocational Rehabilitation Service Delivery System." Final Report submitted to RSA/OSERS (December 1980), II-5.
3. JWK International Corporation, "An Assessment...," II-7.
4. Rehabilitation Services Administration, Fiscal Year 1981 Annual Report, p. 38.
5. National Institute of Neurological and Communicative Disorders and Stroke, Report of the Panel on Communicative Disorders to the National Advisory Neurological and Communicative Disorders and Stroke Council". U.S. Department of Health and Human Services (June 1979).
6. National Institute of Neurological Diseases and Stroke, Human Communication and Its Disorders: An Overview. U.S. Department of Health, Education and Welfare (1970).
7. National Center for Health Statistics, unpublished data from the 1977 Health Interview Survey.
8. Rehabilitation Services Administration, Fiscal Year 1981 Annual Report, p. 5.
9. National Center for Health Statistics, Health Interview Survey (1977).
10. Bureau of Health Manpower, Health Resources Administration, A Report on Allied Health Personnel (November 1979), p. XIV-5.
11. The Deafness and Communicative Disorders Program: Recommendations for the Future, A Task Force Report Prepared for the Commissioner of Rehabilitation Services (December 1979), p. 4.
12. National Center for Health Statistics, Health Interview Survey (1977).
13. DCDO Task Force Report, Appendix.

VOCATIONAL REHABILITATION SERVICES ADMINISTRATION TRAINING GRANT PROGRAM
SUPPORT FOR SPEECH PATHOLOGY AND AUDIOLOGY



¹Information unavailable
²Funding for 11 continuing SP/A Projects Proposed. No Funding for new SP/A projects proposed.

Appendix A

American Speech-Language-Hearing Association
Governmental Affairs Department
3/83

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REHABILITATION TRAINING EXPENDITURES: PROGRAM/FISCAL DATA
FY 1979 - FY 1982

Category	Actual Expenditures FY 1979 (Thousand)	# of Projects	FY 1980 (Thousand)	# of Projects	FY 1981 (Thousand)	# of Projects	FY 1982 - Projected Continuation	New	Total	FY 1982 - Actual Continuation	New	Total	# of Projects	Estimated # of Trainees
ING IN ESTABLISHED REHABILITATION CIPLINES														
ilitation Counseling	$ 5,062	80	$ 4,612	80	$ 4,435	76	$1,719,000	$ 781,000	$ 2,500,000	$1,738,124	$ 761,876	$ 2,500,000	44	450
ilitation Medicine	3,896	56	2,906	51	3,171	45	1,943,000	457,000	2,400,000	1,935,571	457,005	2,392,576	35	160
ilitation Facility Administration	1,620	13	1,514	13	1,470	12	742,000	458,000	1,200,000	741,580	458,420	1,200,000	11	500
hetics and Orthotics	1,048	7	1,322	7	320	5	149,000	1,151,000	1,300,000	148,907	1,151,000	1,299,907	7	180
d Health Professions	2,968	112	2,048	104	1,551	75	531,000	469,000	1,000,000	529,916	472,863	1,002,779	36	212
ech Pathology and Audiology	1,351	50	1,012	47	628	36	230,000	100,000	330,000	230,358	175,001	405,359	17	70
upational Therapy	309	20	280	19	335	10	73,000	69,000	142,000	72,404	74,774	147,178	5	30
sical Therapy	605	26	401	23	296	14	66,000	75,000	141,000	65,464	82,440	147,904	6	42
sing	88	1	71	1	66	1	51,000	75,000	126,000	50,932	--	50,932	1	10
ial Work	205	3	132	3	60	2	68,000	--	68,000	68,000	--	68,000	1	10
chology	40	4	46	4	70	3	--	100,000	100,000	--	87,569	87,569	2	25
rapeutic Recreation	130	8	98	7	80	3	43,000	50,000	93,000	42,788	53,059	95,847	2	25
velopment and Placement	197	2	197	2	144	2	--	1,000,000	1,000,000	--	1,000,000	1,000,000	5	350
tional Evaluation	902	10	664	10	547	10	288,000	512,000	800,000	275,344	512,020	787,364	11	270
ental and Innovative	1,622	18	1,317	18	1,291	15	740,000	--	740,000	739,301	--	739,301	8	90
[illegible]	860	9	855	9	700	10	347,000	353,000	700,000	303,856	333,697	637,553	10	90
	1,326	10	687	9	616	8	224,000	276,000	500,000	249,572	275,990	525,562	7	80
ity III	189	3	179	3	179	3	87,000	113,000	200,000	86,720	113,000	199,720	3	40
graduate Education	818	28	554	28	454	21	155,000	145,000	300,000	155,000	214,201	369,201	28	-
	1,206	9	720	9	875	8	568,000	232,000	800,000	526,333	290,643	816,976	7	160
Sub-Total	$22,262	357	$17,863	341	$15,375	296	$7,493,000	$5,947,000	$13,440,000	$7,429,614	$6,039,575	$13,469,189	305	3,533
preters for the Deaf	--	-	900	10	900	10	--	900,000	900,000	--	900,000	900,000	10	
DEVELOPMENT & TRAINING FOR EMPLOYED ABILITATION WORKERS														
ilitation Continuing Education Programs	3,172	15	3,017	15	2,966	13	--	2,000,000	2,000,000	--	2,000,000	2,000,000	12	1,750
In-Service Training	2,792	78	3,151	78	3,177	74	--	2,800,000	2,800,000	--	2,800,000	2,800,000	74	-
form Training	1,906	94	557	8	--	-	--	60,000	60,000	--	30,811	30,811	-	-
arch Fellowships	37	2	30	2	--	-	--	--	--	--	--	--	-	-
Sub-Total	7,907	[illegible]	6,755	[illegible]	6,143	[illegible]	$7,493,000	$11,707,000	$19,200,000	$7,429,614	$11,770,386	$19,200,000	301	5,283
GRAND TOTAL	$30,169	[illegible]	$25,518	[illegible]	[illegible]	[illegible]	$7,493,000	$11,707,000	$19,200,000	$7,429,614	$11,770,386	$19,200,000	301	5,283

Appendix B

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Table 3. Clinical Manpower Needs for Audiologists Compared to Manpower Resources, 1973-1985

Forecast for the period	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Audiological service needs:													
Screening (infants)	733	739	746	752	758	765	771	777	783	790	796	802	809
Screening (3-18)	777	776	775	774	773	772	771	769	768	767	766	765	764
Habilitation (3-18)	4998	4990	4983	4976	4968	4961	4954	4946	4939	4932	4924	4917	4910
Hab. severely impaired (3-18)	5831	5822	5814	5805	5796	5788	5779	5771	5762	5754	5745	5736	5728
Testing medical purposes	3047	3079	3112	3145	3177	3210	3243	3275	3308	3341	3373	3406	3439
(Re)habilitation (adults)	3481	3537	3591	3645	3700	3754	3808	3862	3916	3971	4025	4079	4133
Testing in industry	96	96	96	96	96	96	96	96	96	96	96	96	96
Total need	18963	19039	19117	19193	19268	19346	19422	19496	19572	19651	19725	19801	19879
Audiology workforce resources:													
Continuing audiologists	2330	2565	2819	3094	3390	3706	4043	4401	4779	5178	5597	6038	6498
New audiologists													
B.S. graduates	68	71	77	82	86	91	95	100	104	108	113	117	122
M.S. graduates	345	373	401	429	457	485	513	541	569	597	625	653	681
Ph.D. graduates	7	7	8	8	9	9	10	10	11	11	12	12	13
Attrition	144	154	163	172	181	190	199	208	217	226	235	244	253
Inactive	41	43	48	51	55	58	61	65	68	71	74	78	81
Projected supply of audiologists	2565	2819	3094	3390	3706	4043	4401	4779	5178	5597	6038	6498	6980
Net need	16398	16220	16023	15803	15562	15303	15021	14717	14394	14054	13687	13303	12899

Source: Speech Pathology and Audiology: Manpower Resources and Needs. Washington, D.C.: Government Printing Office, 1977.

Appendix C

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Table 4. Clinical Manpower Needs for Speech Pathologists Compared to Manpower Resources, 1973-1985

Forecast for the period	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Speech pathology service needs:													
Screening (3-18)	518	517	517	516	515	514	514	513	512	511	511	510	509
Habilitation (3-18)	62971	62879	62786	62693	62601	62508	62416	62323	62230	62138	62045	61952	61860
Habilitation and testing (adults)	3242	3292	3343	3393	3444	3494	3545	3595	3646	3696	3747	3797	3847
Hab. severely hearing impaired	5831	5822	5814	5805	5796	5788	5779	5771	5762	5754	5745	5736	5728
Total need	72562	72510	72460	72407	72356	72304	72254	72202	72150	72099	72048	71995	71944
Speech pathology workforce resources:													
Continuing speech pathologists	18377	20226	22223	24368	26662	29101	31692	34430	37316	40149	43530	46860	50338
New speech pathologists													
B.S. graduates	2314	2358	2501	2645	2788	2912	3075	3219	3362	3506	3649	3791	3936
M.S. graduates	1684	1821	1957	2094	2231	2368	2505	2642	2778	2915	3052	3189	3326
Ph.D. graduates	34	36	39	41	43	45	48	50	52	54	57	59	61
Attrition	1690	1797	1903	2079	2115	2222	2328	2414	2500	2647	2753	2859	2963
Inactive	393	421	449	477	506	534	562	591	619	647	675	704	732
Projected supply of speech pathologists	20226	22223	24368	26662	29101	31692	34430	37316	40149	43530	46860	50338	53964
Net need	52336	50287	48092	45745	43255	40612	37824	34886	32001	28569	25188	21657	17980

Source: Speech Pathology and Audiology: Manpower Resources and Needs. Washington, D.C.: Government Printing Office, 1977.

Appendix D

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PREPARED STATEMENT OF DR. PATRICK J. McDONOUGH, ASSOCIATE EXECUTIVE VICE PRESIDENT AND DIRECTOR OF PROFESSIONAL AND GOVERNMENT AFFAIRS, AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION AND AMERICAN REHABILITATION COUNSELING ASSOCIATION

The American Personnel and Guidance Association (APGA) and its 41,000 members, including the American Rehabilitation Counseling Association (ARCA), a division of APGA, appreciate the opportunity to present our views on the reauthorization of the Rehabilitation Act of 1973, as amended.

Our statement is directed toward the need for realistic authorizations of the Rehabilitation Act of 1973, as amended, for at least a three-year period. This extension is vitally needed to add a measure of stability in the Rehabilitation programs that span our nation and serve to develop the potential of millions of disabled people.

The Rehabilitation Act of 1973 is a model of positive thinking and direction of what can be done in the area of human services. The State-Federal partnership and its effects over the past six decades stands as a shining example of the importance of Federal leadership in reaching those that need services the most.

We wish to go on record as encouraging the Congress to maintain the mandate as it currently exists. We are also aware of the fact that several sections of the law have not been implemented due to a lack of appropriations. Some examples of Congressionally mandated, but unfunded sections include: Evaluation (Section 14). Innovation and Expansion (Section 120), Comprehensive Rehabilitation Centers (Section 305), to name but a few.

A balanced approach to providing rehabilitation services was what the Congressional architects had in mind, and this is expressed in the law itself. Direct services are stressed, however, the research component and the training section are sadly underfunded.

The trend in the past three years has been less and less students selecting careers in Rehabilitation, and unless this catastrophic trend is reversed, the number of competent and well-trained Rehabilitation staff will continue to diminish. The complex job of Rehabilitation simply cannot be done without trained personnel.

Our Recommendation: We urge that the authorization for "Rehabilitation Training" be at least $29 million (up from the current level of $19.2 million). These funds would help to reverse the dangerous circumstance that now exists.

We also urge the Congress to increase authorizations for the research activities of the National Institute for Handicapped Research (NIHR). The efforts of this Institute are geared toward the development of new techniques and devices to enhance the independence of disabled persons, thus reducing the tax burden.

Our Recommendation: We urge that authorizations for Research efforts (through NIHR) be increased to $50 million from its current level of $30 million. This type of increase, while not overwhelming, would certainly help to generate new and cost-saving approaches and devices for disabled persons in their goal of independence.

"Few, if any, resources offer more potential, I think, than our 35 million disabled Americans. Too often they are relegated to the sidelines in spite of outstanding abilities. I am proud to participate in this International Year (referring to the International Year of Disabled Persons, 1981) to help increase the awareness of each and every one of us, committed that we'll make that extra effort to assist the disabled in moving into the mainstream of American Life." President Reagan made that statement, and we would have to agree on its worth, and it is just as relevant in 1983 as we plan for the years ahead.

We will not bore you with the well-known statistics of just how much "Rehabilitation pays" and how expensive neglect can be to the taxpayer.

On behalf of the 41,000 members of APGA and the American Rehabilitation Counseling Association, we urge you to consider the following:

1. Keep the Rehabilitation Act of 1973, as amended, in its current form.
2. Increase the authorization levels for FY '84 and beyond for Training of Rehabilitation Staff.
3. Increase the authorization levels for Research for FY '84 and beyond.
4. Do not allow Rehabilitation programs, as authorized by the Act, to be a part of any Block Grant or "megablock grant" as curiently proposed by the Administration.

Speaking for our membership, but more important, the beneficiaries of the Rehabilitation programs, we urge you to keep in mind that your deliberations and action will help millions of handicapped citizens partake in the American Dream.

THE NATIONAL ASSOCIATION
FOR THE
DEAF - BLIND

2703 Forest Oak Circle
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1st VICE PRESIDENT
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Mountain Plains Region

Patricia McCallum
Texas Region

March 8, 1983

The Honorable Austin J. Murphy,
Chairman
Select Education Subcommittee
U.S. House of Representative
617 House Annex #1
Washington, D.C. 20515

Dear Mr. Murphy:

I have been informed that you will hold hearings on Vocational Rehabilitation on 21 and 23 March. My written testimony follows:

My name is Robert H. Petty, Executive Director, the National Association for the Deaf-Blind. I am also a Due Process Hearing Officer, State Department of Education, State of Oklahoma and a member of the Governor's Advisory Committee for Handicapped Concerns, State of Oklahoma. I am the father of a 28 year old deaf-blind son. He is the first deaf-blind student to graduate from the University of Oklahoma. Over the last 25 years I have been officially involved with the deaf-blind, as well as other disabled, from the school district to the White House.

There is no question that Vocational Rehabilitation has enjoyed much success. However, if we are to improve the system, it may be more constructive to examine its possible faults rather than point to its merits.

First, existing programs tend to serve those who are least disabled or handicapped. Additionally, existing programs usually

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fail to serve those who are most disabled. Therefore, the programs may not be in compliance with public law. [See P.L. 93-112 "with special emphasis on services to those with the most severe handicap."] Moreover, they violate the basic tenents of cost-effectiveness.

The foregoing practices result from the manner in which the disabled are perceived by service providers. They also result from how service providers perceive their own self interests (i.e., job security). Most are caught up in a "Catch-22" situation. Conventional Vocational Rehabilitation wisdom subscribes to the proposition that "case closure" equates to "rehabilitation." To put the point in another way, the higher the percentage of "successful" case closures, the more successful the Vocational Rehabilitation Counselor is perceived to be by his superiors and by the system. This reality disposes counselors to select those clients who are less disabled and, therefore, have the highest probability of successfully completing a training program in the shortest time possible. However, in the larger and more significant context, in terms of the national interest, this is a myopic and costly attitude in terms of the expenditure of tax dollars, and the manner in which the disabled are served.

The obvious consequence of not training or of undertraining those "with the most severe handicaps" is that they will be institutionalized or placed in some other inappropriate setting. Many will be so placed for some thirty or forty years at an expense of at least $20,000 a year in terms of present day dollars. This situation needs to be changed. This can be done if vocational rehabilitation adopts a program akin to "weighted" case closures. This system presupposes that some clients may need services for a protracted period, some for a lifetime. This would remove the temptation of vocational rehabilitation personnel to favor those clients who are less disabled and would remove the penalty for "unsuccessful" or premature case closures of clients who are more severely handicapped. I am informed by policy level vocational rehabilitation personnel in Washington, D.C. that they can "successfully" close a case of a severely handicapped client in 24 months. However, upon closer examination, the reality is that upon completion of training most of these people are simply returned home. Many are officially classified as "homemakers."

Such practice may be consistent with the letter of the law, but it violates the spirit of the law in a most egregious fashion. I would also suggest that P.L. 95-602 Title VII be funded at a realistic level. (Part A--Comprehensive Services, Part B--Centers for Independent Living, and Part C--Independent Living Services for Older Blind Individuals.) Again, adequate funding is a less costly and a more humane approach than the "normal" alternative of institutionalization.

Vocational Rehabilitation personnel should make common cause and effort with authorities in education so that they could acquire a client upon the completion of his/her conventional education and should have a vocational rehabilitation plan and training program "in-place."

The handicapped should be viewed and defined essentially in terms of how well, or poorly, they function and in terms of their potential, rather than placing an undue reliance on the medical model.

A precedent for this suggestion is the change of classification of the severely disabled from a specific disability (e.g., retardation and epilepsy) to a functional definition (see P.L. 95-602, Title V.)

At present, Vocational Rehabilitation Counselors who receive a college degree in this field, receive relatively little training in how to effectively interface a client with the "work world". Curriculum should be modified to accommodate this need.

P.L. 95-602, Part B., Section 621 and 622 are concerned with "Projects with Industry and Business Opportunities for Handicapped Individuals." Both programs or Sections should be adequately funded.

At present, Vocational Rehabilitation Counselors and Service Providers require partial or entire new "workups" on clients. This is required even though recent and definitive information exists. This requirement is expensive and should be terminated.

To the maximum extent possible, rehabilitative services and programs should be provided in the community. You could change the present practice simply by changing the present funding arrangement. In those unusual instances, when deaf-blind clients require a variety of services at a single location, support services could be provided at Regional Centers for the Deaf-Blind (i.e., Talladega, Alabama or Sacramento, California.) This approach is more cost-effective than programs presently in place.

On behalf of the organization which I represent, I sincerely appreciate the opportunity provided to comment on matters pertaining to Vocational Rehabilitation. I trust that my remarks are not seen as harsh or accusatory. They have been proffered honestly, without stint or favor.

I further hope that they will make a modest contribution to your review and hearings.

Sincerely,

Robert H. Petty
Executive Director

Consortium for
Citizens with
Developmental
Disabilities

Training and Employment Task Force
Charles F. Dambach, Chairman
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Training and Employment Task Force

of the

Consortium for Citizens with Developmental Disabilities

Statement Relative to

REAUTHORIZATION OF THE REHABILITATION

ACT OF 1973, AS AMENDED

March 18, 1983

Members of the Training and Employment Task Force include:

Association for Children/Adults with Learning Disabilities

Association for Retarded Citizens

Disability Rights Education & Defense Fund

Epilepsy Foundation of America

Goodwill Industries of America

National Association of Private Residential

Facilities for the Mentally Retarded

Council of State Administrators

of Vocational Rehabilitation

National Rehabilitation Association

National Association of Protection & Advocacy Systems

National Association of Rehabilitation Facilities

National Easter Seal Society

National Society for Children and Adults with Autism

United Cerebral Palsy Association, Inc.

Introduction

The Training and Employment Task Force of the Consortium for Citizens with Developmental Disabilities (CCDD) is composed of organizations which serve persons with disabilities. A list of Task Force members endorsing this statement is on the cover page. These organizations provide services for and represent the needs of millions of developmentally disabled Americans. The Task Force members wish to thank the Subcommittee for its continued interest in and support of the Rehabilitation Act and its programs. Many of the people who are served by programs of the Rehabilitation Act are affiliated with our organizations, and a significant portion of the people we serve have been helped by Vocational Rehabilitation programs. Therefore, we are vitally concerned with the extension of the Act.

Persons with developmental disabilities often have substantial impairments which offer a unique challenge to the rehabilitation community. The purpose of this statement is to highlight those programs within the Rehabilitation Act which have an impact upon the lives of persons with life-long and severe disabilities. Some of the persons whom we represent may only require a minimum of services in order to achieve independence and employability. Other individuals may require more intensive habilitation/rehabilitation services in order to reach their full human potential. All components of the Act are vital and if they all were funded and worked together, then a full continuum of services would be available for persons with disabilities. This Task Force is ready to assist the Subcommittee as it continues its deliberations on programs which are authorized within the Rehabilitation Act.

The Task Force endorses extension of the Act for at least three years and increased authorized funding levels to meet the need for services. The Task Force firmly believes that all programs within the Rehabilitation Act should be renewed. Vocational Rehabilitation programs are a proven, cost-effective method of providing vital services to persons with disabilities. Since there has been a decrease in the number of disabled persons served and rehabilitated over the past few years, we feel particularly strongly that the authorization should be increased for the Basic State Grant Progam.

In addition, certain programs have exceptional potential for increasing the number of disabled persons placed into competitive jobs and expanding the independence of disabled persons. The Task Force feels that programs such as Independent Living and Projects With Industry should receive significantly increased authorizations to accomplish these purposes. We also wish to suggest a modification in the Client Assistance Program.

New Federalism

This year, the Reagan Administration has again proposed that the Rehabilitation Act be included in New Federalism or block grant proposals. These proposals would dilute the focus of the program and would take away the strong financial base needed to provide continuity. The Rehabilitation Program has always been a cooperative arrangement between the federal government, state government and the private, nonprofit rehabilitation community. The Vocational Rehabilitation Program is already a predominantly state-run program. In FY 1983, 91 percent of the monies available under the Rehabilitation Act were allotted to and matched by the states to provide services to disabled people. The balance of the funds are spent on research, training, independent living and various demonstration programs which can best be managed from the national level. The federal presence helps assure equitable distribution of resources and reasonably uniform standards. Thus, turning the program completely over to the states would not achieve administrative savings and could cause duplication of research and training programs. The dissemination of knowledge gained from national level experimental and demonstration projects would be lost since few states would have the resources necessary to engage in such large-scale efforts. Therefore, this Task Force is opposed to any attempts to include the rehabilitation programs in any block grant or "New Federalism" proposal.

State Grants

The central component of the Rehabilitation Act is the State/Federal Rehabilitation Program. Now in its 63rd year, this program continues as the focus of our nation's effort to assist disabled Americans in their effort to become gainfully employed. In recent years, however, the caseload volume has declined significantly. The number of persons rehabilitated in FY 1982 declined 11.3% from the previous year. This decline can be partially attributed to decreases in the purchasing power of the rehabilitation dollar resulting from the effects of high inflation. The resources available to state agencies were further reduced when Social Security Vocational Rehabilitation funding was cut from $124 million in FY 1981 to approximately $3 million in FY 1982. Approximately 110,000 eligible persons went unserved by state vocational rehabilitation agencies as a result of this funding decrease.

Finally, continued emphasis on providing services to persons with severe disabilities requires more intensive rehabilitation efforts. We fully support this emphasis, but recognize that it places a greater demand on the limited funds available. In FY 1982, 59.6% of all persons served were severely disabled; the highest such proportion ever recorded.

Despite the inadequate resources, the program continues to serve and rehabilitate disabled persons who have the potential to work. Financing should be increased in order to serve more of the eligible persons who go unserved. Therefore, the Task Force recommends that the legislation extending the Rehabilitation Act contain authorizations for Basic State Grants under Section 110(b) (1) of the Rehabilitation Act of 1973, as amended, equal to $1,037.8 million in Fiscal Year 1984; $1,141.1 million in Fiscal Year 1985; and $1,254 million in Fiscal Year 1986.

These authorizations would in part achieve the goal of restoring the purchasing power of the rehabilitation dollar to the 1979 Section 110 federal spending level. FY 1979 is viewed as the last year in which the State/Federal Rehabilitation Program operated at full strength. In order to adequately and effectively meet the vocational needs of disabled persons, it is imperative that we increase the authorization to these levels.

Independent Living

Title VII of the Rehabilitation Act authorizes several different approaches to promoting independent living services, particularly services to persons too severely disabled to qualify for vocational rehabilitation. The 1978 amendments to the Act envisioned a major statewide service delivery system, "Comprehensive Services for

Independent Living," in Part A. However, the Administration and Congress have restricted the program to the federally administered Part B Centers for Independent Living by failing to request and appropriate monies for the Independent Living state grant program. These centers are often staffed by professionally-trained disabled persons who assist clients in obtaining appropriate services, training and employment necessary to achieve independence. More importantly, the staff also provides crucial peer support that can be the key to the successful transition from dependence to independence.

The primary concern of the Task Force with the Independent Living program is how to create a transition from a federally-administered series of model and demonstration centers which have proven their value to a statewide service delivery system for the severely disabled population. A key factor to implementing this transition is the start-up of Part A while maintaining funding continuity for existing Part B centers. The Task Force believes the success of Part B justifies the expansion of the program at this time.

When enacted, Title VII of the Act offered great potential. It remains a vital key to the door of employment opportunity for disabled people. But we are dismayed that Parts A and C have not been funded. Title VII is a comprehensive attempt to provide the support, resources and assistance crucial to gaining independence. For many severely disabled people, the Independent Living program provides the alternative to costly institutional care. Now is the time to let Title VII begin to reach its full potential.

The Task Force recommends that $60 million be authorized for independent living services. This would allow for $33 million to initiate Part A, $24 million to maintain Part B and $3 million to initiate Part C.

Projects With Industry

The Projects With Industry (PWI) program authorizes contracts or jointly-financed cooperative agreements with employers and organizations for projects designed to prepare disabled individuals for gainful employment. Such projects provide training, employment, and other services in work settings. PWI increases the chances for successful placement because the client is exposed to and placed in a real work environment. The process of permanent placement is simplified because the employer already knows the client and only a payroll transfer may be required to hire a PWI graduate. Business and industry are more involved with the client, and attitudinal barriers are reduced. PWI is part of an overall rehabilitation program with special emphasis on placement. Last year, 72 PWI projects were funded at $8 million. Over 9,000 placements, costing an average of $946 each, made this a successful job-training program. Placement retention rates were over 75%. The average annual wage for PWI graduates was $9,000; total income for persons placed by the program was $78 million. Taxes paid by PWI graduates alone offset the cost of the program.

The success of the PWI program and its positive cost benefit ratio justify an authorization amount of $25 million for the next three fiscal years. Documented savings in public assistance and taxes paid by the program clearly exceed the authorization for this program.

Other Progams of Significance

The Task Force has addressed authorization levels for some of the major components of the Act. But the Act is composed of a variety of programs concerning training, research, recreation and rehabilitation services. Each component reinforces the others, together constituting a program capable of providing a statutory base for the appropriate rehabilitation services necessary for each individual. Following are some of the programs vital to the continued strength of the Act:

Rehabilitation Training

- Rehabilitation, because it is individually tailored to the unique needs of each disabled person, depends upon well-prepared professionals to deliver a wide range of services. Whether the service is medical, psychological, social, or vocational, the quality of the service provided is directly related to the qualifications of the provider. A strong training program to provide qualified personnel is integral to an effective service delivery program, and we regret that funding for Rehabilitation Training has gradually declined over the past six years from $30.4 million in 1977-78 to $19.2 million in FY 1983.

Special Demonstrations

- The Rehabilitation Act authorizes Special Demonstrations "which hold promise of expanding or otherwise improving services to (severely) handicapped individuals." Special Demonstration Projects and centers are on the cutting edge of developing and refining methods by which the vocational rehabilitation program improves its capability to successfully serve severely disabled persons. The scope of the projects is national, with the emphasis on the development of projects which can be replicated in all states once service delivery models have been refined.

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Recreation

- The role of recreation in rehabilitation is an important one. Recreation and rehabilitation professionals indicate that there is a significant therapeutic value to participation in recreation programs and that recreational activities are an essential element of a balanced lifestyle. When Congress passed Section 316, it recognized that the lack of adequate recreation programming for disabled individuals was one of the most glaring gaps in our existing social service funding. Continued support for Section 316 programs is essential to make recreational opportunities accessible to persons with disabilities.

Client Assistance

- The Client Assistance Program was established in 1973, along with due process procedures, to strengthen the clients' voice in the rehabilitation process and provide the clients with a means of redress if the process was not responsive to their needs. Gradually 37 states have agreed to participate. In most states, the VR agencies have opted to run the program within the agency. Approximately five states have placed the CAP program in external independent advocacy agencies. To guarantee that all clients can obtain the information and services necessary for successful rehabilitation, the Task Force suggests the following modifications within Section 112 of the Act.

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a) Make it mandatory for all states and territories to provide a Client Assistance Program.

b) Authorize funds necessary for a minimum allocation to each state and territory.

c) Revise the language to state more clearly that rehabilitation agencies have the option to operate the Program internally or to place it in an external independent advocacy agency.

National Institute of Handicapped Research

- The National Institute of Handicapped Research (NIHR), which was established under the "Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978," promotes expanded research in both traditional and innovative fields of rehabilitation. The Institute also provides support for the dissemination of information acquired through such research and coordinates federal programs and policies related to research in rehabilitation. Despite initial Congressional intentions of significantly expanding research in the area of rehabilitation, the NIHR budget has consistently received a smaller appropriation than the initial funding level of $31.5

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million in FY 1979 and FY 1980. In addition to fewer absolute dollars, NIHR funding has also been further eroded by inflation. By shortchanging the research aspects of vocational rehabilitation, as has been the case since the establishment of NIHR, we are denying the best possible services and outcomes to persons with disabilities, as well as undercutting the success of the vocational rehabilitation program. The Task Force recommends an authorization level of $40 million.

Innovation and Expansion

- Innovation and Expansion Grants are authorized by Section 120 of the Act. These monies allow state vocational rehabilitation agencies to pursue innovative programs which might not otherwise be funded by the basic state grant program. Traditionally these monies have been used to serve unserved or underserved populations such as mentally retarded individuals, persons with cerebral palsy, and disabled persons who are also disadvantaged. This program was last funded in FY 1980 at a level of $11.775 million. The Task Force recommends that Innovation and Expansion Grants be authorized at the 1980 level, at a minimum. We believe that these monies can be used for a number of activities which will enhance employment opportunities for the severely disabled. For instance, a part of these monies could be used to apply rehabilitation engineering to the

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worksite, thus enabling many persons heretofore thought to be "unemployable" to take their rightful place in the working world. Finally, the Task Force believes that these grants should be reauthorized because they provide the opportunity for rehabilitation agencies to use creative methods to help the hard-to-serve client. While we are fully cognizant of the fact that these are difficult economic times, we feel that unless such innovative programs are allowed to continue, rehabilitation for the severely disabled will suffer both now and in future years.

Reauthorize Unfunded Programs

The Task Force also asks the Subcommittee to reauthorize the programs that have remained unfunded. As we noted previously, the Rehabilitation Act must be viewed as a comprehensive plan addressing all the rehabilitation needs of a diverse disabled population. We will urge Congress to appropriate funds for these programs and projects. The unfunded programs include: Grants for Construction of Rehabilitation Facilities (Sec. 301); Vocational Training Services for Handicapped Individuals (Sec. 302); Loan Guarantees for Rehabilitation Facilities (Sec. 303); Comprehensive Rehabilitation Centers (Sec. 305); Community Service Employment Programs for Handicapped Individuals (Title VI, Part A); Business Opportunities for Handicapped Individuals (Sec. 622); and Protection and Advocacy of Individual Rights(Sec. 711).

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The Act Must be Extended

The primary point that the Task Force wishes to make is that the Act must be extended. The various components of the Act have proven their effectiveness in providing the best possible balance of rehabilitation services to a diverse client population. We must maintain and, in some cases, expand research, training programs, and services to meet needs that are currently not being met. We appreciate the opportunity to submit this statement to you and look forward to working with the Subcommittee to ensure that all disabled persons have the opportunity to become productive, independent individuals.

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STATEMENT

RESPECTFULLY SUBMITTED TO THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE HOUSE COMMITTEE ON

EDUCATION AND LABOR

ON

THE

EXTENSION OF THE REHABILITATION ACT

ON BEHALF OF

UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

THE CHESTER ARTHUR BUILDING

425 "EYE" STREET, N.W., SUITE 141

WASHINGTON, D.C. 20001

Prepared by Kathleen M. Roy, Policy Associate
With Contributions by Dr. E. Clarke Ross, Director

March 18, 1983

U C P A Governmental Activities Office   Washington, D.C.

INTRODUCTION

United Cerebral Palsy Associations, Inc., is pleased to submit written testimony to the House Subcommittee on Select Education concerning the reauthorization of the "Rehabilitation Act of 1973" as amended. We commend the Subcommittee for giving consideration to the programmatic needs of our nation's disabled citizens as the Rehabilitation Act is reauthorized. At the outset UCPA, Inc., would like to endorse the comments submitted to the Subcommitted by the Consortium for Citizens with Developmental Disabilities Task Force on Training and Employment. This statement is the result of thoughtful deliberations of several national agencies who represent persons with severe disabilities who require a continuum of rehabilitation services in order to reach their full human potential. UCPA is an active member of the Task Force and we feel that this statement will give the Subcommittee significant direction in a number of programmatic areas including the Basic State Grant Program, Independent Living, Projects with Industry, Client Assistance, NIHR, and other programs which serve persons with disabilities.

In recent years, UCPA has become increasingly concerned about improving employment opportunities for persons with severe disabilities. While many clients are served by the vocational rehabilitation system, all too often these services either do not lead to employment opportunities for disabled individuals or result in employment which may not fully utilize the clients employment skills. We point this out not to be critical of any one segment of the rehabilitation community. Rather, we believe that this is a problem that those concerned about rehabilitation, especially the members of the Subcommittee, should give further consideration. Therefore, our testimony will focus on one solution to this problem: Improving rehabilitation engineering as it relates to employment. UCPA firmly believes that if we improve our ability to adapt the work place, many persons heretofore thought to be "unemployable" will be able to take their rightful place in the working world. Further, our statement will outline some of the problems encountered in the production of adaptive equipment and the response being made by the National Institute of Handicapped Research to this problem. Finally, we will consider how the Independent Living Program serves persons with cerebral palsy.

The Cooperative Agreement

In April 1981, UCPA entered into a Cooperative Agreement with the Rehabilitation Services Administration, the National Institute on Handicapped Research and the Council of State Administrators of Vocational Rehabilitation. The purpose of the Agreement is to improve rehabilitation services and thus, employment opportunities for persons with cerebral palsy. As the Agreement states:

> "While many advances have been made in vocational rehabilitation in the last several decades, the vast majority of persons disabled by cerebral palsy have not been served....
>
> Another critical area for intervention involves increasing employability and employment options. Unfortunately many persons with cerebral palsy are labeled as unemployable, inappropriately placed in sheltered workshops or limited to few employment options. Also, many persons with cerebral palsy have been underserved by the educational system and this factor has further limited their employment options."

The Agreement outlines tasks which each agency will undertake in order to improve employment opportunities for severely disabled individuals. These tasks include the following: long range planning, case finding and referral, data retrieval, professional training, consultation services, regional review and a focus on rehabilitation and independent living skills. Throughout the Agreement the importance of improving rehabilitation engineering as it relates to employment has been stressed.

Since the signing of the Cooperative Agreement, progress has been somewhat slower than our agency had originally anticipated. However, this past fall we hired a full-time rehabilitation professional in our national office to work on the implementation of the Agreement. The following examples of UCP affiliate activities indicate that the agreement will ultimately lead to improved employment opportunities in the future for persons with cerebral palsy:

- Perhaps the best example of cooperation between UCPA and the vocational rehabilitation system can be seen by the efforts of UCP of New York City. This affiliate is involved in placing persons who are currently in sheltered workshop programs into competitive employment. UCP of NYC also provides post employment services which may be needed by these clients. Two years ago, this program had been so successful that the New York Office of Vocational Rehabilitation has signed a contract with UCP of NYC to provide these services to other severely disabled persons.

- UCP of Indiana has hired a full-time rehabilitation engineer to improve employment opportunities for developmentally disabled persons who are currently working in sheltered workshops. This individual serves as a resource person on what technology is commercially available to the employer. He also offers recommendations on how to adapt a worksite for a particular disabled individual. When such worksite modifications are recommended, the rehabilitation engineer focuses not on a single job, but two or three jobs which the person may be able to perform, thus increasing that person's employment potential.

- UCP of the North Shore has undertaken a direct training/on-the-job training program for severely disabled adults. There are currently nine enrollees in the program. UCP has met with the Massachusetts Rehabilitation Commission concerning possible funding for this program. It appears that the Massachusetts Rehabilitation Commission will enter into a "purchase-of-service" agreement some time in the future. It is hoped that such an agreement will foster other cooperative ventures.

- As a result of the Cooperative Agreement, UCP of Wisconsin has entered into joint agreement with the Wisconsin Department of Rehabilitation. Specifically, UCP of Wisconsin is working with rehabilitation counselors to make them aware of the services which can be provided through the use of an occupational therapist and/or rehabilitation engineer in adapting the worksite for severely disabled persons. UCP of Wisconsin is using the work done by the Job Development Laboratory at George Washington University as a model.

- UCP of Alameda-Contra Costa Counties has been working with RSA Region IX to improve services for persons with cerebral palsy. The affiliate and the regional office have had extensive information sharing including statistics concerning the number of persons with cerebral palsy served in the state of

California. At the local level, UCP of Alameda-Contra Costa Counties is working with DVR to develop an on-the-job training program for persons with severe disabilities.

Need for Technology

Persons who are involved with the employment of the severely disabled generally agree that rehabilitation engineering and job adaptation are essential to assuring that these persons obtain suitable employment. One rehabilitation professional put it this way:

> "The potential contribution of rehab technology toward the employability of persons with cerebral palsy is immeasurable.... My sense is that a great deal of technology is already in place and the difficulty lies in applying it to the individual consumer at a cost which can be borne. At the present time it appears that only a very small segment of consumers have had the opportunity to benefit from rehab engineering for purposes of employment. My thought is that unless the rehab technology is in place during the consumer's period of education/training, the chances of matching the technology to a job is decreased. What....a consumer needs (is) the input and equipment available through rehabilitation engineering techniques early in life because if not, they probably will not be "tracked" for employment."

Perhaps more important is the fact that a government study has reached similar conclusions. The Berkely Planning Associates, in conjunction with Harold Russell Associates, has recently completed a study concerning the accommodations made on behalf of handicapped workers by federal contractors. This study for the Department of Labor "sought to provide a better base for implementing Section 503 of the Rehabilitation Act of 1973..." The 20-month study surveyed 2,000 federal contractors concerning the nature and extent of the accommodations made for disabled employees but only 367 responded. In addition, 85 telephone interviews were conducted to obtain more detailed information concerning the types of accommodations made. A survey of disabled workers was also taken to "learn about any accommodations that may have been made for them." Finally, case studies were done of ten firms who were identified as having "exemplary accommodation practices."

The study made the following conclusions which may interest the Subcommittee:

- An overall conclusion of the analysis is that for firms which have made efforts to hire the handicapped, accommodation is "no big deal".... Only 8% of the accommodations cost more than $2,000.
- "Accommodation efforts are generally perceived as successful in allowing the worker to be effective on the job."

- "Accommondations for individual workers take many forms: adapting work environments and location of the job, retraining or selectively placing the workers in jobs needing no accommodation; providing transportation, special equipment or aides, redesigning the worker's jobs and re-orienting or providing special training to supervisors and co-workers. No particular type of accommodation dominates. Most workers received more than one kind of accommodation."

The study draws a number of conclusions, but the following may be of special interest to the Subcommittee. They recommend the government:

- "Provide technical assistance and possibly cost-sharing in accommodation. This may particularly be needed with the small business sector, which is both the source if a disproportionate share of new jobs being created by the economy, and also the sector least likely to hire and accommodate the handicapped due to limited personnel systems, diversity of occupations, and inexperience with accommodations Government-funded rehabilitation engineering centers are one possible source of expertise, but more locally available sources are needed, possibly drawing on state VR programs for supply." (Emphasis added)

It should be pointed out that of the firms surveyed 28% reported having no handicapped workers. An additional 17% have made no accommodation. Only 55% have made some form of accommodation. Thus, while this study demonstrates the value of adapting the worksite to disabled individuals, it also points out the need to increase our focus in this area.

Efforts of Vocational Rehabilitation

As we have already illustrated through some examples of the ways in which our Cooperative Agreement is being implemented, several vocational rehabilitation agencies have become involved in rehabilitation engineering as it relates to employment. The following are some examples of efforts being made by vocational rehabilitation agencies either on their own or in conjunction with other agencies or institutions. By using these illustrations, we do not wish to infer that these are the only efforts vocational rehabilitation is making in this area. Rather, these examples are meant to offer the Subcommittee ideas of how rehabilitation engineering can be used by vocational rehabilitation agencies.

- The Iowa Department of Rehabilitation was funded as a Comprehensive Rehabilitation Center during FY 80 and 81. Drawing on the work done by Dr. Kali Mallik at the Job Development Laboratory at George Washington University, the Iowa DVR developed a unique method to increase employment opportunities for severely disabled persons. A team of professionals composed of a rehabilitation counselor, a professional in job training and development, and an individual knowledgeable in adaptive equipment work together to solve the unique problems faced by severely disabled clients. This team looks at problems encountered at the worksite and other environmental factors including the individual's living arrangements. While this project is no longer funded as a Comprehensive Rehabilitation Center, at this point they have been able to maintain this valuable service.

- In New York, Rensselaer Polytechnic Institute was awarded a Research and Training grant from NIHR to work with the New York Office of Vocational Rehabilitation. Through this grant, students from Rennselear were used to assist placement staff with job analysis and work site modifications to maximize employment opportunities for persons with severe disabilities. This newly established relationship will provide DVR with placement and counseling staff with first-hand information on the effective use of rehabilitation engineering techniques to maximize client employability.

- The Department of Vocational Rehabilitation in Michigan has applied rehabilitation engineering in a variety of ways. First, in cooperation with Michigan State University, DVR of Michigan supplied two students, who are both severely disabled by cerebral palsy and are nonverbal, with a computerized speech device. This device enables these students, to speak and pursue work in computer programming. DVR of Michigan in conjunction with the University of Michigan has also developed a Mobile Laboratory to develop worksite modifications. This Mobile Laboratory visits the client's worksite and makes recommendations about any modifications the client might need. DVR of Michigan also works directly with clients to prepare them for the work experience and teach them how they might also modify their work environments themselves. DVR of Michigan feels strongly that the majority of modifications which need to be made for the disabled employee often are similar, if not identical, to those modifications which private industry makes in order to increase productivity.

- In New Jersey, the Department of Vocational Rehabilitation is working with the Metheaney School to improve rehabilitation engineering services for clients. The Metheaney School serves severely disabled children and adolescents, many of whom are multiply disabled. DVR is trying to develop a cadre of volunteers who have some type of engineering skill and are willing to assist in making modifications for these clients. DVR will pay for any purchase of equipment or materials which may be needed in order to complete a given modification. This technique matches the skills of the volunteer to the needs of the individual client and also stretches scarce service delivery dollars further. Since many of the students at the Metheaney School are adolescents who are either employed or preparing for the world of work, this program will no doubt increase their employability.

These are a few examples of efforts being made by various state departments of Vocational Rehabilitation. The professionals we surveyed in preparing the above examples all agree on one important point: While some efforts are being made to increase the utilization of rehabilitation engineering, much more needs to be done. Many feel that the practical application of rehabilitation employment.(i.e., the modification of the worksite to meet the functional needs of the client), is essential to placing severely persons in the work place.

NIHR Initiatives

Currently, the National Institute of Handicapped Research funds 18 Rehabilitation Engineering Centers (RECs). Of these only one, Center Industries Corporation, (which is affiliated with UCP of Kansas) is concerned primarily with employment. The Center Industries Corporation of Wichita, Kansas, aided by technical assistance from Wichita State University, is primarily a job shop operation providing support for local Wichita in the basic areas of fabrication, matching, and assembly. It employs the physically handicapped alongside the able-bodied in a 75% handi-capped-25% able-bodied ratio. Diagnostic test procedures and testing hardware have been designed to determine the physical capabilities and job requirements. As a result, severely disabled workers are generally meeting industrial norms and receiving unsubsidized wages, thus taking their new status as contributors to society.

Recently, Center Industries Corporation has begun to work with employers to provide incentives for industry to hire severely disabled persons. They continue to believe that, while much progress has been made in recent years toward improving worksite modifications for disabled workers, much more should be done. They also believe that much knowledge exists which is not always shared throughout the rehabilitation community. They point out that many exemplary programs could be replicated if such information were disseminated. They hasten to point out that many people envision rehabilitation engineering as an expensive endeavor when in fact the majority of worksite modifications can be made at a reasonable cost.

Beyond the problems of timely dissemination of this information, the problem arises of who will manufacture adaptive equipment at a cost disabled persons can afford. The NIHR Long-Rang Plan, developed in 1981, has this to say about the manufacturing of adaptive equipment:

> "Technological devices can be largely developed and distributed through the facilities, research capacity, staff, management, market expertise, and distribution networks of private industry. However, there are now several disincentives to private industry investment in this area: lack of adequate information about market demand; obstacles caused by the patent system, the third-party payment system, and liability insurance requirements; and the fact that some of these undertakings may be unprofitable because of high investment costs for a very limited market. NIHR's immediate goals are to reduce these obstacles by (1) initiating a program of demographic research, including market surveys of the handicapped population; (2) determining the necessary incentives to offset the low returns anticipated from investment; and (3) studying and testing policy modifications to offset other specific obstacles."

We are pleased to learn that NIHR intends to award a grant this year to focus on the above cited goals. In addition, this grant will look at performance standards and evaluation of adaptive equipment to assure the quality of equipment produced for use by disabled persons. UCPA intends to work with NIHR on this matter.

The Office of Technology Assessment of the Congress has also considered the unique problems in the production of technology to meet the needs of handicapped individuals. In their report entitled Technology and Handicapped People specifically addresses the problems of production, marketing and diffusions of disability-related technologies.

> "The production, marketing, and diffusion of technologies are steps that are most often appropriate private sector activities, and yet a number of factors work against that sector's willingness and ability to engage in those activities. Research and development (R&D) organizations have typically placed a low priority on production, marketing, and diffusion activities. The National Aeronautics and Space Administration's (NASA's) activities in technology transfer illustrate an exception. In general, however, the ultimate commercial production and distribution of technologies being developed with Federal funds have not been given sufficient attention."

To address this problem the OTA report recommends the following:

> "Congress could amend current legislation to create a consistent and comprehensive set of fiscal and regulatory incentives encouraging private industry to invest in the production and marketing of disability-related technologies."

The report goes on to explain that:

> "...this option recognizes the current confusing and often detrimental collection of competing incentives set up by such laws. It implicitly is based on several ideas: 1) that a great many technologies, though certainly not all, could be serving far more people than currently; 2) that some, perhaps many, technologies' development and subsequent distribution depends less on further research than on the willingness and ability of private industry to develop, produce, and market them; 3) that policies of the Government greatly affect private industry's willingness and ability to produce and market these technologies; and 4) that current legislation and regulations do not create adequate positive incentives for those firms to do so."

We believe that this and other OTA recommendations warrant further consideration by the Subcommittee. This is clearly a complex issue and there are no easy answers. However, production and dissemination of technology is essential to improving the quality of life for disabled persons. We have focused our attention in this statement on technology as it relates to employment, but we readily acknowledge that technology can improve the quality of a disabled person's life in other areas including independent living and increased mobility. NIHR has made some laudable first steps in improving technology in general and rehabilitation engineering specifically. But much remains to be done, especially in the area of dissemination of information and production of equipment.

Comprehensive Services For Independent Living

One of the most exciting federal initiatives of the last decade was the enactment in 1978 of the Independent Living program. Part A of Title VII of the Rehabilitation Act envisioned a major statewide service delivery system. UCPA is very concerned that both the Congress and the Carter and Reagan Administrations have restricted the program to the federally administered Part B Centers for Independent Living, CILs.

The primary concern of UCPA with the Independent Living program in 1983 is how to create a transition from a federally administered series of model and demonstration centers which have proved their value to a statewide service delivery system for the severely disabled population. UCPA recommends the reauthorization of and funding for the Part A program.

Importance to Persons with Cerebral Palsy

Individuals disabled with cerebral palsy are a primary category of persons served through the existing CILs. For example:

- Of the 759 individuals served by the five CILs in Wisconsin between October 1, 1980 and March 31, 1982, 87 or 11% were disabled with cerebral palsy.

- Of 322 consumer respondents from 12 of the then 16 existing CILs in California in 1978, 11.3% were disabled by cerebral palsy. A comparison group or quasi-control group was used in this California Department of Rehabilitation study (June 1982). The comparison group was a random selection of applicants who had been denied state VR services and were not being served by either DVR or the CILs. Only 4.2% of the 286 comparison group were disabled with cerebral palsy.

- Of 23 CILs in California serving 8,666 clients between October 1, 1981 and September 30, 1982, 639 (or 7.37%) were developmentally disabled.

Service Contributions of CILs

CILs provide an array of services generally not available from other government programs or offered only to persons meeting means tested eligibility programs such as Medicaid. For example:

- Of the 4,131.7 monthly average number of clients served by California's 23 CILs between October 1, 1981 and September 30, 1982, the monthly average of clients by service were:

    1) Peer Counseling, 887.0
    2) Unique direct service, 844.2
    3) Attendant Care, 743.6
    4) Housing Assistance, 678.6
    5) Advocacy, 636.2
    6) Transportation, 370.9
    7) Communication, 361.9
    8) Independent Living Skills, 266.1
    9) Employment, 215.3
    10) Equipment repair/loan, 148.8

- With little variance from center to center, the most frequently needed services in Wisconsin's five centers between October 1, 1980 and March 31, 1982 were the following: Personal Care Assistance/Attendant Care, Information and Referral, Independent Living Skills Assessment and Training, Peer Counseling, Housing Assistance, and Transportation.

- Of considerable significance in the five Wisconsin centers were changes in the residential status during the course of service. As a Region V Rehabilitation Services Administration report observes, "The large increase in the 'own home' category represents one of the major triumphs of the independent living program." The residential status change follows:

Status	Percent at Referral	Percent at Closure	Difference
Hospitals/alcohol/drug centers	10.5	4.9	- 5.6
Nursing homes	7.6	6.3	- 1.3
Community residential facility	2.0	1.0	- 1.0
Special arrangements	.8	1.3	+ .5
Parent/relative's home	22.0	12.0	-10.0
Own home	52.0	68.0	+16.0
Unreported	5.1	6.5	

- When clients are terminated from a Wisconsin center program, the counselor is asked to assess the overall independent living status of the individual as to whether his/her situation has improved, not improved, or can not be assessed. For the 301 clients that were closed between October 1, 1980 and March 31, 1982, the following status changes were indicated:

Improved	201 (67%)
Not Improved	80 (27%)
Not possible to Assess/Not Indicated	20 (6%)

UCPA Recommendations

To live and work in the community is the goal of severely disabled Americans. We believe that this goal can be achieved through expanding the current Independent Living Program and through encouraging the development, dissemination and utilization of rehabilitation engineering. We believe that rehabilitation engineering can be provided inexpensively and can improve working conditions for most disabled persons who are or wish to be employed. The following are our specific recommendations as the Congress seeks to reauthorize the Rehabilitation Act:

- Congress should support the CCDD Training and Employment Task Force recommendation that the legislation extending the Rehabilitation Act contain authorizations for Basic State Grants under Section 110 (b) (1) of the Rehabilitation Act of 1973, as amended, equal to $1,037.8 million in Fiscal Year 1984; $1,141.1 million in Fiscal Year 1985; and $1,254 million in Fiscal Year 1986. These authorizations would in part achieve the goal of restoring the purchasing power of the rehabilitation dollar to the 1979 federal spending level.

- Congress should reauthorize Innovation and Expansion Grants which are authorized through Section 120 of the Act. Historically these monies have been used to serve unserved and underserved populations such as persons with cerebral palsy. This program was last funded in FY 1980 at a level of $11.775 million. We recommend that Innovation and Expansion

Grants should be requthorized at the 1980 levels at a minimum. Further the Congress may wish to specificly direct a portion of these monies to be specificly directed to expanding employment opportunities through rehabilitation engineering.

- RSA should be directed to increase their efforts to improve dissemination of information concerning rehabilitation engineering so that counselors are aware of 1) the availability of such technology and how it can be utilized to improve employment opportunities for severely disabled individuals and, 2) where to contact persons who have expertise in making worksite modifications for persons with disabilities.

- UCPA recommends that both Part A and B of Title VII be reauthorized and that the authorizing committees of the Congress instruct the appropriations committees to fund Part A. The Consortium for Citizens with Developmental Disabilities (CCDD) Task Force on Budget and Appropriations, cochaired by UCPA, has recommended an appropriation of $45 million which would allow $25 million to initiate Part A, $18 million to maintain Part B, and $2 million to initiate Part C.

- Through increased funding, NIHR should be directed to fund other Rehabilitation Engineering Centers which are specifically directed to employment.

- The Congress should direct NIHR to improve their efforts to disseminate the knowledge which they have already gained through existing Rehabilitation Engineering Centers as well as other exemplary programs which provide assistance in worksite modification.

- Congress should give further consideration on how to improve the incentives to manufacturing adaptive equipment through drawing on knowledge gleaned from current studies being done at NIHR as well as the work which has been done by the Office of Technology Assessment.

We appreciate the opportunity to submit written testimony concerning the reauthorization of the Rehabilitation Act. We look forward to working with the Subcommittee as the Act is extended.

- Independent Living Citations

1) Hichle, Gene and Robins, Bridget. Programs for People: The California Independent Living Centers. Sacramento, CA: State of California Department of Rehabilitation, June 1982.

2) State of Wisconsin, Department of Health and Social Services, Department of Vocational Rehabilitation. Centers for Independent Living. Madison, WI: State of Wisconsin Department of Vocational Rehabilitation, September 15, 1982.

3) U.S. Department of Education, Rehabilitation Services Administration, Region V. The Economic And Societal Benefits of Independent Living Services. Chicago, IL: U.S. Rehabilitation Services Administration, Region V, December, 1982.

National Association of Counties
Offices • 440 First Street, N.W. Washington, D.C. 20001 • Telephone 202/393-NACO

March 10, 1983

The Honorable Austin Murphy
U.S. House of Representatives
Chairman, Subcommittee on
  Select Education
Committee on Education and Labor
Washington, DC 20515

Dear Mr. Murphy:

Thank you for this opportunity to submit written testimony regarding the reauthorization of the Vocational Rehabilitation Act of 1973.

Should you or your staff have any questions regarding the attached testimony, please contact me at 393-6226.

Sincerely,

Patricia Johnson Craig

Patricia Johnson Craig
Director
Department of Human Resources

Attachment

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WRITTEN TESTIMONY SUBMITTED ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES (NACO)* TO THE SENATE SUBCOMMITTEE ON THE HANDICAPPED AND THE HOUSE SUBCOMMITTEE ON SELECT EDUCATION IN REGARD TO AUTHORIZATION OF THE REHABILITATION ACT OF 1973.

THE NATIONAL ASSOCIATION OF COUNTIES WOULD LIKE TO THANK YOU FOR THIS OPPORTUNITY TO SHARE OUR VIEWS AND CONCERNS REGARDING REAUTHORIZATION OF THE VOCATIONAL REHABILITATION ACT OF 1973.

NACo CONTINUES TO SUPPORT EQUAL OPPORTUNITY FOR HANDICAPPED AMERICANS IN ALL ASPECTS OF AMERICAN LIFE, INCLUDING EMPLOYMENT, PROGRAMS, ACTIVITIES, EDUCATION AND SERVICES. WE FEEL THAT THE PROGRAMS FUNDED THROUGH THE VOCATIONAL REHABILITATION ACT HAVE PROVIDED A GOOD BEGINNING TOWARD THE PROMOTION OF SELF-SUPPORT AND SELF-RELIANCE OF DISABLED PERSONS.

ALTHOUGH VOCATIONAL REHABILITATION PROGRAMS ARE, FOR THE MOST PART, FUNDED AND ADMINISTERED THROUGH THE STATE LEVEL, THESE PROGRAMS HAVE HAD A SIGNIFICANT AND BENEFICIAL IMPACT ON COUNTY GOVERNMENTS AND CONSTITUENTS. MOST COUNTIES NOW DIRECTLY REFER DISABLED PERSONS WHO NEED INFORMATION OR ASSISTANCE WITH TRANSPORTATION OR EMPLOYMENT CONCERNS TO VOCATIONAL REHABILITATION AGENCIES. IN MANY STATES, THERE ARE VIRTUALLY NO OTHER SERVICES SPECIFICALLY GEARED TO MEET THE NEEDS OF DISABLED PERSONS AVAILABLE FOR ADDITIONAL

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*NACo IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN AMERICA. ITS MEMBERSHIP INCLUDES URBAN, SUBURBAN, AND RURAL COUNTIES JOINED TOGETHER FOR THE COMMON PURPOSE OF STRENGTHENING COUNTY GOVERNMENT TO MEET THE NEEDS OF ALL AMERICANS. BY VIRTUE OF A COUNTY'S MEMBERSHIP, ALL ITS ELECTED AND APPOINTED OFFICIALS BECOME PARTICIPANTS IN AN ORGANIZATION DEDICATED TO THE FOLLOWING GOALS: IMPROVING COUNTY GOVERNMENT, SERVING AS THE NATIONAL SPOKESMAN FOR COUNTY GOVERNMENT; ACTING AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT, AND ACHIEVING PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

REFERRALS OF THIS KIND. VOCATIONAL REHABILITATION OFFICIALS OFTEN PARTICIPATE IN VARIOUS COMMUNITY RELATIONS ACTIVITIES SUCH AS INTER-AGENCY COMMITTEES AND BOARDS WITH COUNTY OFFICIALS. VOCATIONAL REHABILITATION OFFICIALS OFTEN SERVE ON PRIVATE INDUSTRY COUNCILS AND LOCAL CHAMBERS OF COMMERCE. THESE KINDS OF FORMAL INTERAGENCY LINKAGES ASSIST COUNTIES TO EFFECTIVELY SERVE DISABLED CONSTITUENTS BY PROVIDING PERSONS WITH EXPERTISE IN HANDICAP EMPLOYMENT ISSUES.

VOCATIONAL REHABILITATION STAFF ASSIST COUNTIES WITH CONSULTATION REGARDING ARCHITECTURAL ACCESS QUESTIONS OR QUESTIONS RELATING TO MODIFICATION OF EQUIPMENT FOR HANDICAPPED EMPLOYEES. IN MANY CASES, SUCH AS SANTA CLARA COUNTY, CA, THE STATE VOCATIONAL REHABILITATION AGENCY PROVIDES FUNDS TO SUPPORT A LOCAL INDEPENDENT LIVING CENTER. SANTA CLARA COUNTY ALSO PROVIDES FUNDING TO THIS CENTER IN RECOGNITION OF ITS VALUE TO COUNTY CONSTITUENTS. OTHER COUNTIES UTILIZE VOCATIONAL REHABILITATION'S PROVISION OF INTERPRETER SERVICES TO HEARING-IMPAIRED STUDENTS OF COMMUNITY COLLEGES.

NACo IS CONCERNED TO NOTE THAT, ALTHOUGH VOCATIONAL REHABILITATION PROGRAMS HAVE NOT RECEIVED SIGNIFICANT CUTS IN FUNDING, THE PURCHASING POWER, DUE TO INFLATION, HAS BEEN REDUCED STEADILY SINCE 1975. THE NUMBER OF CLIENTS SERVED BY VOCATIONAL REHABILITATION HAS STEADILY DECREASED SINCE 1979.

AT THE COUNTY LEVEL, THIS DECREASE HAS RESULTED IN A NOTICEABLE CUTBACK IN SERVICES TO COUNTY CONSTITUENTS. WHILE STILL PROVIDING DIRECT REFERRAL TO VOCATIONAL REHABILITATION, COUNTY OFFICIALS NOW CAUTION DISABLED CALLERS THAT THEY MAY NOT RECEIVE THE SERVICES THEY NEED. OFFICIALS HAVE NOTED THAT VOCATIONAL REHABILITATION CASES ARE SOMETIMES CLOSED PREMATURELY, LEAVING DISABLED PERSONS NOT READY FOR

COMPETITIVE EMPLOYMENT AND WITH NO OTHER ALTERNATIVE FOR ASSISTANCE. A RECENT INSTANCE OF THIS OCCURRED IN MONTGOMERY COUNTY, MARYLAND WHEN GRADUATES OF MAINSTREAMED PUBLIC EDUCATION CLASSES WERE DENIED VOCATIONAL TRAINING.

DISABLED PERSONS UNABLE TO RECEIVE VOCATIONAL TRAINING ARE NOT ABLE TO FIND COMPETITIVE EMPLOYMENT. THE END RESULT IS THAT DISABLED PERSONS WHO ARE CAPABLE OF SELF-SUFFICIENCY BECOME BURDENS TO ALREADY OVERTAXED INCOME-SUPPORT PROGRAMS. POTENTIAL TAXPAYERS BECOME RECIPIENTS OF FEDERAL, STATE AND COUNTY ASSISTANCE.

NACo URGES YOUR SUBCOMMITTEE TO CAREFULLY REVIEW THIS SITUATION AND TO BEGIN TO PROVIDE APPROPRIATIONS AUTHORITY THAT REFLECTS INCREASES IN THE CPI TO VOCATIONAL REHABILITATION PROGRAMS. THIS ACTION WOULD ASSURE COUNTIES THAT THE LEVEL OF VOCATIONAL REHABILITATION SERVICES WILL REMAIN CONSTANT.

U.S. DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION
AND REHABILITATIVE SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D.C. 20202

INFORMATION MEMORANDUM
RSA-IM-82-29
July 7, 1982

TO : STATE REHABILITATION AGENCIES (GENERAL)
STATE REHABILITATION AGENCIES (BLIND)
RSA REGIONAL COMMISSIONERS

SUBJECT: Economic Gains for Individuals and Governments Through Vocational Rehabilitation

The accompanying two reports provide estimates of the economic gains to individuals and governments attributed to the provision and successful completion of rehabilitation services in the State-Federal program.

One report, prepared in April and issued at the time to RSA staff, presents a series of benefit/cost ratios through Fiscal Year 1980 which express the long-term benefits to individuals. A large portion of this report is devoted to an explanation of the methodology used to derive the national ratios. The other report, dated July, 1982 summarizes the key findings from the earlier effort and adds the following: a) a chart illustrating the trend in the benefit/cost ratios for the last ten years for which data are available, b) a first-time statement on the different benefit/cost ratios for severely and non-severely disabled persons, and c) a text and table describing the benefits that accrue to Federal, State and local governments because of the rehabilitation of disabled individuals.

The projections in these reports are complete for cases closed through Fiscal Year 1980. They reveal that the State-Federal program is cost-beneficial whether one considers only the impact on individuals or only the gains to governments. It is estimated, however, that these gains, both to individuals and governments, will be somewhat lower when the benchmark data for Fiscal Year 1981 are available.

Commissioner of Rehabilitation Services

Attachments

ECONOMIC GAINS THROUGH VOCATIONAL REHABILITATION:

PROJECTED BENEFITS FOR INDIVIDUALS AND GOVERNMENTS

Rehabilitation Services Administration
Division of Program Administration
Basic State Grants Branch
July, 1982

Economic Gains Through Vocational Rehabilitation

A. Benefits for Individuals

It is estimated that lifetime earnings for persons rehabilitated in Fiscal Year 1980 through the State-Federal program will improve by $10.4 for every dollar spent on services for all clients whose cases were closed in that year. This was the fifth consecutive year for which the projected benefit/cost ratio has been greater than $10 to $1 but less than $11 to $1. On the whole, State rehabilitation agencies have been fairly successful in maintaining the benefit/cost ratios within this narrow range despite a) rising costs, b) decreasing numbers of persons being rehabilitated and c) increasing proportions of severely disabled persons for whom remunerative outcomes are less likely.

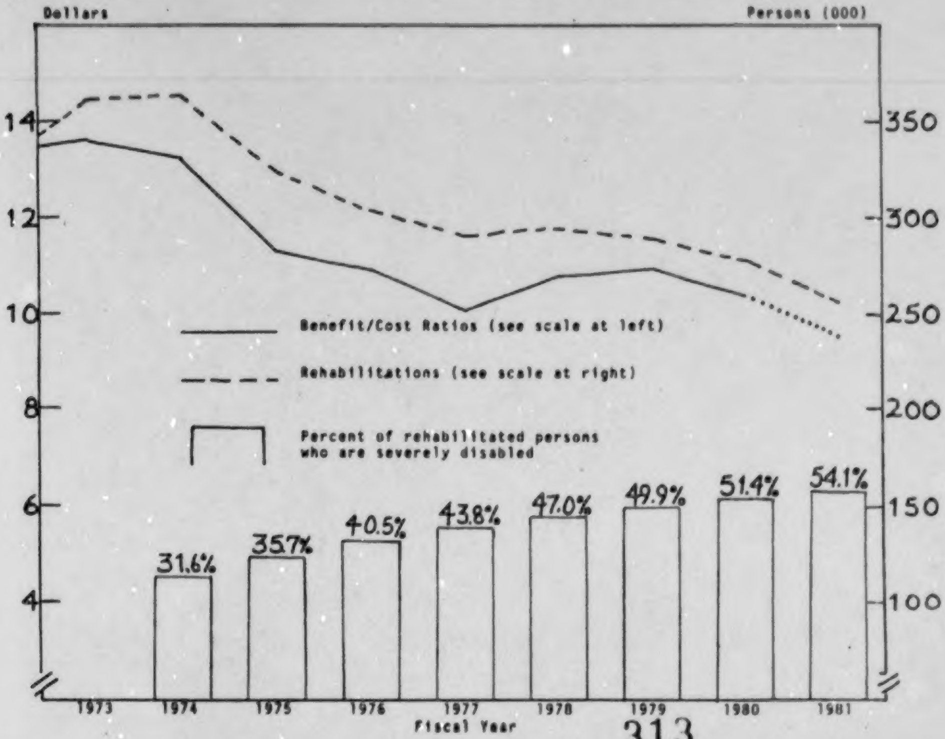
The Fiscal Year 1980 projection of $10.4 to $1, however, was $0.5 to $1 less than the projection for the previous year. The main reasons for this decline were a) a loss in the number of rehabilitations between the two years of 11,200 and b) a continuing rise in the proportion of severely disabled persons among those rehabilitated, this time to 51 percent. In light of an additional loss of 21,300 rehabilitations in Fiscal Year 1981 and a further increase in the proportion of the severely disabled to 54 percent, another decline in the benefit/cost ratio is expected, quite possibly below $10 to $1, when the latest earnings and cost data become available.

The calculated benefit/cost ratios for severely and non-severely disabled persons whose cases were closed in Fiscal Year 1980 show a considerable difference in the apparent impact of rehabilitation services on the two groups. For the severely disabled the estimated lifetime improvement in earnings came to $8.0 for each dollar of cost. For the non-severely disabled, the ratio came to $14.6 for each dollar. This difference is brought about by the greater likelihood of the severely disabled to be rehabilitated without earnings or with low earnings in sheltered workshops.

B. Benefits for Governments

In the first year after case closure, persons rehabilitated in Fiscal Year 1980 are expected to pay to Federal, State and local governments an estimated $211.5 million more in income, payroll and sales taxes than they would have paid had they not been rehabilitated. In addition, another $68.9 million will be saved as a result of decreased dependency on public support payments and institutional care. The grand total first year benefit to governments, therefore, will be $280.4 million. At this rate, the total governmental benefit will equal the total Federal, State and third-party cost of rehabilitation for Fiscal Year 1980 closures in four years. The projected governmental benefits in subsequent years, however, are expected to decline because of known and expected losses in rehabilitations and higher proportions of severely disabled persons who have reduced earnings potential.

Benefit/Cost Ratios, Persons Rehabilitated, and Proportion of Severely Disabled Persons Rehabilitated, Fiscal Years 1973 - 1981



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Estimated First-Year Benefits to Governments Resulting
From Rehabilitations in Fiscal Year 1980

Governmental benefits	Annualized Projections		
	Before VR	After VR	Difference
		(millions of dollars)	
1. Social Security payroll taxes	$18.0	$106.7	$88.7
2. Income taxes: Federal	18.6	105.4	86.8
3. Income taxes: State and local	2.9	15.5	12.6
4. Sales taxes: State and local	6.0	29.4	23.4
5. Subtotal: Governmental revenues (lines 1 to 4)	$45.5	$257.0	$211.5
6. Public assistance payments	103.3	70.3	33.0
7. Public institutional costs	86.0	50.1	35.9
8. Subtotal: Governmental outlays (lines 6 and 7)	$189.3	$120.4	$68.9
9. TOTAL governmental benefits (lines 5 and 8)	—	—	$280.4

NOTE 1: Governmental revenues are projections annualized from weekly earnings at referral and at rehabilitation closure as reported on Form RSA-300. Public assistance payments are projections annualized from monthly receipts at referral and at rehabilitation closure from the same source document. Institutional costs have as their base the numbers of persons residing in institutions at referral as also reported on Form RSA-300.

NOTE 2: Other benefits to government such as savings in Social Security Disability Insurance benefits are not included.

IN-HOUSE BENEFIT/COST RATIOS:

STATE-FEDERAL PROGRAM OF VOCATIONAL REHABILITATION

FISCAL YEARS 1971 TO 1980

Rehabilitation Services Administration
Division of Program Administration
Basic State Grants Branch
April, 1982

In-House Benefit/Cost Ratios: State-Federal Program of Vocational Rehabilitation - Fiscal Years 1971 to 1980

SUMMARY ANALYSIS

The State-Federal Program of Vocational Rehabilitation provides a wide variety of services to persons with mental and physical disabilities to enable them to find or sustain employment to the limit of their capacities. The benefits of this program accrue not only to private individuals, however, but also to Federal, State and local governments. These benefits can be as obvious and tangible as an increase in earnings and tax contributions among rehabilitated persons, or as intangible as a heightened sense of personal worth.

The Rehabilitation Services Administration makes annual estimates of the cost-beneficial status of the State-Federal Program. Currently, it utilizes a very simple, straightforward methodology which focuses on only one among many benefits of vocational rehabilitation. 1/ This benefit is the projected increase in lifetime earnings of rehabilitated persons attributed to their receipt of vocational rehabilitation services under the State-Federal Program, per dollar of expenditure on all persons for whom services are terminated. Even this less than comprehensive effort dramatically reveals the impressive gains that disabled persons derive from this program, as the benefit/cost ratios have ranged from 10:1 to nearly 14:1 in the ten years shown in Table A under one series of assumptions. (A methodological summary is presented with this paper.)

One finding derived from Table A is that the projected benefit/cost ratios generally rise and fall with increases or decreases in the number of persons who are rehabilitated. It is highly probable, therefore, that when projections based on earnings and cost data for Fiscal Year 1981 can be made, that the benefit/cost ratio will decline again, perhaps below 10:1, because the number of rehabilitations fell sharply by more than seven percent to about 256,000 for that year. Another factor causing a decline in the benefit/cost ratio would be the rise in the proportion of rehabilitated persons who are severely disabled. This group, less likely to achieve an income-producing outcome, accounted for 56 percent of all rehabilitations in Fiscal Year 1981 compared to 51 percent a year earlier.

Another way to view Table A and, in particular, the benefit/cost ratios in column (6) is to note that the ratios have ranged narrowly from 10.1:1 to 10.9:1 in the last five years despite the persistent decline in rehabilitations in each year but one. This means that State rehabilitation agencies have thus far been fairly successful in combatting the effects of decreased numbers of clients and relentlessly increasing costs by obtaining jobs for rehabilitated clients at wage levels that have risen nearly as much as have costs through the years. For example, the increase in the projected improvement in lifetime earnings between Fiscal Year 1976 and Fiscal Year 1980 was 30 percent compared to an increase of 36 percent in projected total costs on all closures, and a loss of nearly nine percent in persons rehabilitated between the same two years.

It must be noted that no earnings are calculated or assumed in the in-house RSA methodology for the one individual in seven who is traditionally rehabilitated as a homemaker. The rehabilitation costs on these individuals, however, are incorporated into all cost projections. The highly probable future declines in the cost-beneficial status of the State-Federal Program can be offset, at least in part, by encouraging State agencies to find wage-paying employment for higher proportions of their clients.

1/ Other economic benefits such as returns to government are calculated elsewhere and are not included in this report.

This should have the salutary effect of not only maintaining the benefit/cost ratio but also intensifying the employment and wage-finding efforts of State agencies on behalf of their clients.

Table A - Summary of Benefit/Cost Ratios: State Federal Program of Vocational Rehabilitation, Fiscal Years 1971 - 1980

Fiscal Year	Rehabilitations (1)	Improved lifetime earnings ($ billions) (2)	Total costs on all closures ($ billions) (3)	Benefit/cost ratios (2) ÷ (3) (4)
1980	277,136	$11.535	$1.106	$10.6
1979	288,325	11.567	1.066	10.9
1978	294,396	10.890	1.003	10.8
1977	291,202	9.630	.956	10.1
1976	303,328	8.889	.815	10.9
1975	324,039	9.096	.802	11.3
1974	361,138	9.867	.768	12.8
1973	360,726	8.853	.652	13.6
1972	326,138	7.301	.538	13.6
1971	291,272	5.872	.480	12.2

Methodological Summary and Assumptions

Benefit - The only benefit calculated in this projection is improvement in the earnings of rehabilitated wage-earners. No account was taken of increased work activity on the part of rehabilitated homemakers and unpaid family workers, nor were any benefits assumed for clients served but not rehabilitated.

Cost - Costs are estimated for all cases closed, whether rehabilitated, not rehabilitated, or not accepted for services. They encompass purchased services, agency administration and counselor salaries as paid for through Federal, State and other funds. Not included in costs are expenditures for research, counselor training and a variety of discretionary activities.

Source - RSA-300, the Case Service Report, is the source for data on client earnings at the time of referral for services and at rehabilitation closure. The same source provided information on amounts of money spent by State agencies to purchase services for disabled clients. These are the case service costs. Form RSA-2, the annual report on expenditures was, through Fiscal Year 1979, the source of information on the proportion of program expenditures devoted to services for individuals. This proportion is critical to the estimation of total costs on all closed cases and had to be estimated for Fiscal Year 1980.

Key assumptions - The most important assumptions, not previously indicated, are these:

1. The increase in the earnings of rehabilitated persons from referral to closure can be attributed to the provision of rehabilitation services.

2. Earnings at the time of referral for services are indicative of what clients could have earned without the intervention of vocational rehabilitation.

3. The rehabilitated clients will work for no more than thirty years after closure. They will drop out of the job market at the rate of six percent per year because of death, new or recurrent disability, and retirement. At this rate, only 16 percent will work for the full thirty years. (The mean age at referral of persons rehabilitated in Fiscal Year 1980 was 32.[illegible], with as many as three persons in eight under 25 years of age.)

4. Those who remain employed will improve their productivity by a rate of three percent per year.

5. The stream of projected future earnings is to be discounted at the rate of ten percent a year to reflect the preference for having a stated amount now rather than in the future. Discounting is needed to avoid inflating the long-term benefits derived from rehabilitation services. For example, a salary of $20,000 this year cannot be thought of as equivalent to the same salary ten years from now. Under a discount rate of ten percent per year, the $20,000 salary ten years in the future has a present value of only $7,[illegible]. If a higher discount rate is used the resulting benefit/cost ratios will be reduced.

Finally, the decrease in employment of six percent per year, the increase in productivity of three percent per year and the discount rate of ten percent per year, when combined into a single rate, produced a discounting function of twelve percent per year. Thus, the first year's projected improvement in earnings was discounted by twelve percent a year up to thirty years, the assumed "working lifetime". (Had a discounting function of 16 percent per year been used, the resulting benefit/cost ratio would have been [illegible]:1 instead of 13.[illegible]:1.)

Table 1 -- Mean weekly earnings of rehabilitated clients at referral and closure projected to annual rates, Fiscal Years 1971 to 1980

Fiscal Year	Rehabili-tations	Mean weekly earnings 1/		Annual aggregate earnings 2/		
		At Referral	At Closure	At Referral	At Closure (millions of dollars)	Difference 3/
1980	277,136	$22 20	$125.60	$308	1,740	1,432
1979	288,325	19.15	118.74	276	1,712	1,436
1978	294,396	17.27	109.11	254	1,606	1,352
1977	291,202	15.91	98.17	232	1,429	1,198
1976	303,328	16.23	88.84	246	1,347	1,101
1975	324,039	15.81	85.47	256	1,385	1,129
1974	361,138	14.36	82.21	259	1,484	1,225
1973	360,726	14.26	76.17	257	1,356	1,099
1972	326,138	15.12	69.96	247	1,141	894
1971	291,272	14.44	64.49	210	939	729

1/ Encompasses all rehabilitated clients, even those with zero earnings.

2/ Weekly earnings were annualized by multiplying by 50 and then by the total number of rehabilitations.

3/ This is a measure of earnings improvement in the first year after rehabilitation assumed attributable to the vocational rehabilitation process.

Table 2 -- Computation of costs used in projecting benefit/cost ratios relative to clients whose case were closed out in Fiscal Years 1971 to 1980

	COST: From Form RSA-300			
Fiscal Year	Total rehabilitations (1)	Mean case service cost 1/ (2)	Case service $ for rehabs as prop. of case service $ on all closures (3)	Adjusted case service cost on all closures 2/ ($ million) (1 x 2) ÷ (3) (4)
1980	277,136	$1,446	.697	$574.9
1979	288,325	1,361	.708	554.2
1978	294,396	1,276	.705	532.8
1977	291,202	1,215	.703	505.4
1976	303,328	1,066	.721	448.6
1975	324,039	1,003	.737	441.0
1974	361,138	869	.791	396.5
1973	360,726	821	.797	371.6
1972	326,138	771	.793	317.1
1971	291,272	742	.789	273.9

(See footnotes on next page)

Fiscal Year	COST: From Form RSA-2 ($ millions)			
	Total program costs 3/	Total case service costs 3/ 4/	Case service costs as proportion of total (6) ÷ (5)	Adjusted total cost on closures 5/ (4) ÷ (7)
	(5)	(6)	(7)	(8)
1980	$1,202.3 6/	NA	.52 est.	$1,105.3
1979	1,238.2	$644.7	.52	1,085.8
1978	1,132.3	611.1	.53	1,003.3
1977	1,093.4	583.4	.53	933.6
1976	1,046.6	571.3	.55	813.3
1975	997.6	532.4	.53	865.8
1974	877.5	464.6	.53	748.1
1973	772.6	437.6	.57	631.9
1972	727.2	426.5	.59	537.5
1971	653.8	376.5	.57	480.5

1/ For rehabilitated clients on whom State agencies incurred case service expense.

2/ Assumes that non-State agency sources incurred costs at the same rate as State agencies for cases where services were provided without cost to State agencies.

3/ Includes annual Basic Support, Trust Funds, SSI Funds and I & E expenditures.

4/ Includes annual cost of services for individual and the business enterprise program.

5/ This is the estimated grand total cost on all cases closed out each year. Cost encompasses services for individuals, program administration, counselor salaries, etc. as incurred by Federal and State governments and third parties, including clients themselves.

6/ This is an estimate of expenditures based on grants to States.

NA-Not available. Expenditure data for Fiscal Year 1980 not collected.

Table 3 - Present value of improved earnings projected for five to thirty years for clients rehabilitated in Fiscal Years 1971 to 1980 and discounted at twelve percent a year (billions of dollars)

Fiscal Year of closure	Improvement in earnings discounted at 12% per year					
	Years after rehabilitation closure					
	5	10	15	20	25	30
1980	$5.162	$8.091	$9.753	$10.696	$11.231	$11.535
1979	5.177	8.113	9.781	10.725	11.263	11.567
1978	4.874	7.639	9.208	10.098	10.604	10.890
1977	4.319	6.769	8.160	8.948	9.396	9.650
1976	3.969	6.221	7.499	8.223	8.635	8.869
1975	4.070	6.379	7.690	8.433	8.855	9.094
1974	4.416	6.921	8.343	9.150	9.608	9.867
1973	3.962	6.209	7.485	8.208	8.619	8.852
1972	3.223	5.051	6.089	6.677	7.012	7.201
1971	2.628	4.119	4.965	5.445	5.718	5.872

NOTE: The values in the table were derived by multiplying the single-year earnings improvement (Table 1, last column) by the following factors:

For the five-year period, 3.605;
For the ten-year period, 5.650;
For the fifteen-year period, 6.811;
For the twenty-year period, 7.469;
For the twenty-five-year period, 7.843;
For the thirty-year period, 8.055.

These factors are the present value of one dollar a year, i.e. an annuity of one dollar discounted at 12 percent per year for the stated number of years.

Table 4 - Benefit/cost ratios: Present value of improved earnings projected for five to thirty years, and discounted at twelve percent per year for clients rehabilitated in Fiscal Years 1971 to 1980 per dollar of cost for every case closed out in Fiscal Years 1971 to 1980

Fiscal Year of closure	Improvement in earnings per dollar of cost					
	Years after rehabilitation closure					
	5	10	15	20	25	30
1980	$4.7	$7.3	$8.8	$9.7	$10.2	$10.4
1979	4.9	7.6	9.2	10.1	10.6	10.9
1978	4.8	7.6	9.2	10.0	10.5	10.8
1977	4.5	7.1	8.6	9.4	9.9	10.1
1976	4.9	7.6	9.2	10.1	10.6	10.9
1975	5.1	8.0	9.6	10.5	11.0	11.3
1974	5.9	9.3	11.2	12.2	12.8	13.2
1973	6.1	9.5	11.5	12.6	13.2	13.6
1972	6.0	9.4	11.3	12.4	13.0	13.4
1971	5.5	8.6	10.3	11.3	11.9	12.2

CHARACTERISTICS OF PERSONS REHABILITATED IN FISCAL YEAR 1980

State-Federal Program of Vocational Rehabilitation

Rehabilitation Services Administration
Office of Program Operations
Division of Program Administration
Basic State Grants Branch

Characteristics of Persons Rehabilitated in Fiscal Year 1980

Introduction

The State-Federal Program of Vocational Rehabilitation is the major national program dedicated to serving disabled individuals to enable them to participate, as fully as possible, in the workforce. The program has played a significant role in its 60-year history in restoring millions of persons to more productive lives. The program has undergone many changes over the years, usually to encompass groups of disabled individuals previously unserved, and to provide better and more comprehensive services to eligible handicapped individuals. As a result of the Rehabilitation Act of 1973 and its amendments, a number of new initiatives were started, most particularly in providing services to those who are the most severely disabled. This latter thrust has had to take place in the face of ever-diminishing resources brought about by inflationary trends in the economy, and the greater cost entailed in serving the severely disabled.

The report provides, in broad terms, insights into who the disabled clientele are in the State-Federal Program, and what happens to them through the receipt of rehabilitation services. The focus is on clients successfully rehabilitated in Fiscal Year 1980 with trends for the two prior years so that inferences are possible about the directions in which the program is heading. One key finding, for example, is that the caseload of rehabilitated persons is increasingly being made up of older persons. This trend explains other changes. Fewer persons are being referred by educational institutions, fewer are mentally retarded, more are orthopedically impaired, and fewer have earnings at closure. These and other trends are seen in Section A of the report.

Not all clients, of course, can be vocationally rehabilitated and this report features a measure showing which characteristics of the clients and the service delivery system lend themselves to a greater likelihood of rehabilitation success. This measure is called "rehabilitation rate" and is derived by dividing the number of rehabilitationsby the sum of successful (rehabilitated) and unsuccessful (not rehabilitated) closures. The rehabilitation rates add analytical depth to the understanding of characteristics and are found in Section B of the report.

The source for the information in this report is the Case Service Report (RSA-300) submitted annually by State rehabilitation agencies. Data will be tabulated for Fiscal Year 1981 as well from the same source. Thereafter, the status of continued reporting on client characteristics is uncertain.

Characteristics of Persons Rehabilitated in Fiscal Year 1980
Summary Observations

Age

The mean age at referral for persons rehabilitated in Fiscal Year 1980 was 33.3 years. In the last few years, the mean age has edged upward with decreasing numbers and proportions of persons under 25 years of age showing up among rehabilitated clients. Despite a loss of more than 11,000 rehabilitations in Fiscal Year 1980 from the year before, increases in the absolute number of persons 55 years old and over at referral occurred. Persons 45 years old or over at referral were likelier than younger clients to be rehabilitated. Indeed, the older the individual, the likelier that a rehabilitation success was achieved. The highest rehabilitation rate was 87.4 percent for those 65 years of age and over at referral. The greater rate of successful rehabilitations of older persons may reflect both a stricter selection for eligibility and the readier acceptance and use of homemaking as a suitable closure status.

Sex

While men continued to comprise the majority of rehabilitations, 51.9 percent in Fiscal Year 1980, the proportion of women rehabilitated continues to grow, 48.1 percent in Fiscal Year 1980 versus 45.8 percent in 1978. Also, women continue to have a higher rate of rehabilitation (68.9 percent versus 60.7 percent). This higher rate reflects the greater likelihood of women being rehabilitated as homemakers.

Race/ethnicity

Racial minorities (Blacks, Asiatics, American Indians) represented a little over one-fifth of the rehabilitations in Fiscal Year 1980 (as well as in the two prior years). Hispanic persons, as an ethnic minority, represented 5.9 percent of the rehabilitations. The rehabilitation rates by race ranged between 56.2 percent for Indians to 65.8 percent for the white majority of rehabilitated clients. The rate for persons of Hispanic origin was 63.2 percent.

Highest grade completed

Forty-eight percent of persons rehabilitated in Fiscal Year 1980 had at least completed high school at the time of referral. This compares to 45 percent among persons rehabilitated two years earlier. This same group was likelier to be rehabilitated than persons who started but did not complete high school. Interestingly, however, the highest rehabilitation rates were noted for persons who did not complete elementary school. These persons were generally older individuals whose rehabilitation rates were, as previously observed, quite high.

Dependents

More than three-fifths (62.5 percent) of the clients rehabilitated in Fiscal Year 1980 had no dependents at all when referred to VR. While no large differences in the rehabilitation rates were seen, the likelihood of success was at its lowest when there were five or more dependents.

Family size

Well over one-fourth (29.1 percent) of the rehabilitated clients lived alone or, possibly, in an unrelated household when referred to VR. This proportion has been rising steadily in recent years. The rehabilitation rate for people who live alone (59.7) was the lowest for any family size grouping. Absence of family support appears to work against rehabilitation success.

Family income

The median monthly income for families of rehabilitated clients, when referred to VR, was estimated at only $349. Only 27 percent of the families had incomes of $600 a month or more. Rehabilitation rates increased progressively with income level, beginning at 58.6 percent for those whose families had incomes under $150 a month, levelling off at about 70 percent for the $500 category and above. Lower incomes clearly are related to diminished rehabilitation success.

Marital status

Among persons rehabilitated in Fiscal Year 1980, 43.1 percent had never married, 32.0 percent were married, 5.0 percent were widowed, and 20.0 percent were divorced or separated. Widowed and married clients were the most likely to be rehabilitated, with rates of 77.2 and 69.4 percent, respectively. This finding is age-related since older clients who are likelier to be either widowed or married typically have higher rehabilitation rates.

Primary source of support

"Family and friends" was the most common primary source of support at referral (45.6 percent of the rehabilitated clients), followed by current earnings (19.3 percent), and public assistance (13.9 percent). Persons who were primarily dependent on public sources of income for support were less likely to be rehabilitated. For example, the rehabilitation rates were 53.8 percent for those primarily supported by public assistance, 48.9 percent for persons in public institutions, and 52.1 percent for those whose SSDI payment was the largest single support source. This compares to 60.4 percent for clients primarily supported by current earnings and 66.7 percent for those supported mostly by family and friends. Dependence on public sources may work as a disincentive to accept employment, because employment can result in the withdrawal or reduction of public support.

Type of institution at referral

Among persons rehabilitated in Fiscal Year 1980, 10.0 percent were residing in a public or private institution when referred to VR. The comparable percentage two years earlier was 11.3 percent. Such clients were rehabilitated at the low rate of 53.7 percent in Fiscal Year 1980, compared to 65.8 percent for clients not residing in an institution at referral. Among types of institutions, there was a wide difference in rehabilitation rates, from only 33 percent for persons in correctional institutions for children to 66 percent for those coming from general hospitals.

Source of referral

Approximately one-fifth (20.2 percent) of the rehabilitated clients had sought VR services on their own. This is typically the single most common referral source of all and the proportion has been rising steadily in recent years. This could indicate a greater awareness of the availability of rehabilitation services on the part of disabled individuals. One grouping of referral sources with large relative declines among rehabilitated clientele were educational institutions, down from 16.6 percent in Fiscal Year 1978 to 13.3 percent in Fiscal Year 1980. This is an outgrowth of the increasing age of State agency clients. Case outcomes varied considerably by source of referral, with the sharpest contrast existing between public and private sources. The cases most likely to be rehabilitated were those referred by private sources such as artificial appliance companies (92.9 percent), physicians (75.2 percent) and individuals other than the clients themselves (69.9 percent). The least likely to be rehabilitated had been referred by mental hospitals - these are usually public - (46.8 percent), correctional institutions (50.4 percent), and Social Security Administration (52.1 percent). Perhaps, clients referred to VR on a voluntary basis have more incentive to pursue rehabilitation than those who are referred to VR to satisfy legislative or administrative requirements. This greater incentive may be related to a lessened eligibility for public support payments.

Major disabling condition/Cause of disability

Orthopedic impairments were the most common disability grouping, accounting for 21.7 percent of the cases closed rehabilitated in Fiscal Year 1980, followed by mental illness (19.4 percent), and mental retardation (11.7 percent). The distribution of disabilities among VR clients reflects the continuing change in emphasis from less to more severely disabled persons as mandated by the Rehabilitation Act of 1973. Rehabilitations among groups of clients thought of as usually, if not always, severely disabled are rising proportionately and, sometimes, absolutely. These include the orthopedically impaired, the deaf and those with psychotic disorders. Also, cases of spinal cord injuries have increased dramatically from 932 rehabilitations in Fiscal Year 1973, when first reported, to 4,522 in Fiscal Year 1980.

There are exceptions to this trend, however. Rehabilitations of blind and severely mentally retarded persons have declined in number in the last two years although their proportions of the total have held fast. A reverse phenomenon, i.e. absolute and relative declines is occurring among groups of clients generally unlikely to be severely disabled. This includes those with character, personality and behavior disorders; genitourinary system disorders; hay fever/asthma; digestive system disorders; and non-blind visual impairments. Yet, even this trend has an exception in the non-deaf hearing impaired who have increased in number both absolutely and proportionately in the last two years.

Rehabilitation rates, by type of disability, often do not conform to the conventional understanding of severity of disability. For example, above average rates occurred among severely disabled groups such as the blind, the deaf, those with missing limbs, and the severely mentally retarded. Similarly, below average rehabilitation rates were noted among persons with character, personality and behavior disorders; and the mildly mentally retarded. At best, therefore, the rehabilitation rate is a crude measure of severity. Other factors besides type and severity of disability, such as age, motivation, work experience, family support and educational background play an important role in determining eventual rehabilitation success.

Severity of disability

The proportion of severely disabled persons among the rehabilitated continued to increase, reaching an all-time high of 51.4 percent in Fiscal Year 1980. As expected, despite the exceptions noted above, severely disabled persons were less likely to be rehabilitated than the non-severely disabled (60.9 percent versus 68.7 percent).

Public assistance status at referral and closure

Almost seventeen percent of the clients rehabilitated in Fiscal Year 1980 were on public assistance at the time of referral, receiving approximately $8.6 million per month, as a group. By the time of closure, 10.6 percent were on public assistance, receiving an aggregate of $5.9 million per month. The net reduction in monthly assistance payments has been declining in recent years. The net reduction of $2.7 million for persons rehabilitated in Fiscal Year 1980 compares to $3.5 million for those rehabilitated two years earlier. Public assistance clients, especially those in receipt of payment at closure, were less likely to be rehabilitated than non-recipients.

Veteran status

Of clients rehabilitated in Fiscal Year 1980, 4.1 percent were veterans. Their rehabilitation rate was 58.5 percent compared to the overall rate of 64.5 percent in Fiscal Year 1980.

SSDI applicants

Those who were applicants for Social Security Disability Insurance benefits (SSDI) at closure comprised 14.7 percent of the rehabilitated clientele in Fiscal Year 1980, over one-half of whom who had been allowed benefits. The rehabilitation rates for both SSDI applicants and beneficiaries were only 53.7 and 51.6 percent, respectively, compared to 67.0 percent for non-SSDI applicants. Most applicants and all beneficiaries are severely disabled and favorable outcomes are less likely.

SSI applicants

Among clients rehabilitated in Fiscal Year 1980, 13.4 percent were applicants for Supplemental Security Income payments (SSI) at the time of closure, the majority of whom had been allowed benefits. Both SSI applicants and recipients were less likely to be rehabilitated than were non-applicants among active case closures (53.9 percent and 52.5 percent, respectively, versus 66.7 percent among non-SSI applicants). Here, too, most applicants and all recipients were severely disabled and rehabilitation success is less assured.

Interestingly, among both SSDI applicants and SSI applicants, the lowest rehabilitation rates were noted for those whose eligibility had not yet been determined (status pending). Conversely, the highest rates among applicants were for those whose benefits had been terminated. This suggests that the hope of a public support payment militates against rehabilitation success, while the loss of such support acts as a spur to a favorable outcome.

Trust Funds cases/SSI funded cases

Cases meeting the special selection criteria permitting the use of Trust Funds for VR services comprised 5.1 percent of the rehabilitations in Fiscal Year 1980, while those meeting such criteria permitting the use of SSI monies for VR services accounted for 3.7 percent. Both groups were much less likely to be rehabilitated than the non-funded cases.

Ever referred by Social Security

One rehabilitated person in eight (12.4 percent) had been referred by the Social Security Administration at some time during the rehabilitation process. Those so referred had a rehabilitation rate of only 57.2 percent compared to 65.6 percent for non-SSA referrals .

Social Security Cases-Summary

The lower rehabilitation rates for Social Security cases, whether applicants, beneficiaries, "special selection criteria" cases or referrals from Social Security are probably indicative of the greater severity of their disabilities compared to non-Social Security cases. The expectation or availability of Social Security payments could readily act as a disincentive to rehabilitation success. Nevertheless, Social Security cases have generally accounted for increasing proportions of rehabilitated cases in recent years.

Time spent in the VR process

Clients rehabilitated in Fiscal Year 1980 spent, on the average, 3.6 months in the referral and applicant statuses, and another 19.7 months from acceptance to closure. The overall mean months spent in VR was about 23 months. The number and proportion of clients spending more than two years in VR has declined somewhat in recent years. The highest rehabilitation rates are associated with persons spending four to twelve months in rehabilitation and, most particularly, four to six months where the rehabilitation rate was 74.1 percent. Clients remaining in the active statuses for a year and a half or more had only about a 60.0 percent chance of being rehabilitated.

Previous rehabilitation experience

Of clients rehabilitated in Fiscal Year 1980, 6.0 percent had been previously rehabilitated and 4.4 percent previously closed not rehabilitated. The rehabilitation rate for persons previously rehabilitated was high, 75.7 percent, while that for persons previously not rehabilitated was low, 31.1 percent.

Types of services provided

A wide range of services is available to disabled persons with potential for gainful employment. Major services provided through the State-Federal rehabilitation program include a variety of training and medical restoration services. If needed, maintenance payments to clients undergoing rehabilitation are provided. Required equipment and occupational licenses are purchased and arrangements for transportation to work are made. Diagnosis and evaluation as well as guidance, counseling and job placement are provided without charge.

Apart from diagnosis and evaluation which virtually every client receives, training was the service most often provided to clients (51.3 percent) followed by physical and mental restorative services (43.2 percent). Within the different types of training, personal and vocational adjustment was the most common (20.6 percent), with college and vocational training next at 12.8 percent and 12.7 percent, respectively. Maintenance was provided to 21.1 percent of the rehabilitated clients. About one-third (35.6 percent) received "other" services which include transportation, business equipment, occupational licenses, and reader and interpreter services. Persons rehabilitated in Fiscal Year 1980 were a little less likely to have received training and a little more likely to have been provided with a medical service than persons rehabilitated one year earlier. This finding, also, is probably related to age since the older client, becoming more numerous in agency caseloads, is likelier to receive medical services and less likely to get training.

Rehabilitation rates varied by type of service. Training was associated with a lower rehabilitation rate (64.8 percent) than were physical and mental restorative services (77.8 percent). However, the highest rehabilitation rate of all was reported for on-the-job training (78.2 percent). It may be assumed that this type of training arranged in concert with private industry, best helps to develop the productive potential of the disabled individual and increases the chances for favorable rehabilitation outcomes. It is, therefore, unclear why only 5.8 percent of persons rehabilitated in Fiscal Year 1980 had received this service compared to 6.0 percent of persons rehabilitated in Fiscal Year 1979 and 6.9 percent in Fiscal Year 1978. In absolute terms, the loss has been over 4,000 persons between Fiscal Year 1978 and Fiscal Year 1980.

Cost of purchased services

The average case service cost per case rehabilitated in Fiscal Year 1980 was $1,343. This represents a 13 percent increase from the average case service cost of $1,187 in Fiscal Year 1978. Increasing proportions of cases are costing $2,000 or more each year, reaching 20.4 percent of all persons rehabilitated in Fiscal Year 1980. The likelihood of being rehabilitated rose consistently with increasing case service cost, from 50.6 percent for those served at no cost to the State agency, to 77.7 percent for cases served at a cost of $3,000 and over. Lower amounts of money are spent on persons who are not rehabilitated because services to them are not completed and, sometimes, not even started.

Work status at referral and closure

The economic situation for rehabilitated persons typically improves dramatically from referral to closure. For clients rehabilitated in Fiscal Year 1980, for example, only 18.5 were salaried or self-employed at referral compared to 84.1 percent at closure. Since Fiscal Year 1978, however, the rehabilitated client has been increasingly likely to be employed in the competitive labor market at referral, but less likely to be so employed at closure. In the same span of time, sheltered workshop placements have increased both absolutely and proportionately, while a fairly sharp decline in homemakers occurred in Fiscal Year 1980 compared to Fiscal Year 1979 (a gain of 1,000 homemakers while rehabilitations overall declined by 11,000). These trends may be attributed to the continuing increase of severely disabled persons among those rehabilitated who are less likely to be competitively employed.

Whether a client was gainfully occupied at referral made a marked difference in the rehabilitation outcome. Persons who were competitively or self-employed had rehabilitation rates of nearly 82 percent while those who began the rehabilitation process as homemakers stood an 86 percent chance of being rehabilitated. Persons least likely to be rehabilitated were those with no identifiable activity at referral, the "not working-other" category, for whom the rehabilitation rate was only 58 percent.

Occupation at closure

The wide range of occupations into which clients are placed upon completion of the rehabilitation process reflects their different backgrounds in educational attainment, work history, job skills and type and severity of disability which they bring to the program. Trends in the distribution of rehabilitated clients by occupation for the three years in this report are mixed. For example, the proportion of closures into professional and related fields declined slightly in Fiscal Year 1979 from Fiscal Year 1978, but increased to 13.3 percent in Fiscal Year 1980. Similarly, homemakers continued a four-year decline in their proportion in Fiscal Year 1979 reaching 14.1 percent that year, but rose fairly sharply to 15.1 percent in Fiscal Year 1980. Other trends, however, were steadier. Clerical placements have increased both proportionately and absolutely in the last two years while jobs in industry have decreased in both measures, in the same time span.

Weekly earnings at referral and closure

The mean earnings of clients rehabilitated in 1980 was $126 per week at the time of closure including those with zero earnings (i.e. homemakers and unpaid family workers). At referral, the same group was averaging only $22 a week. Increasing proportions of rehabilitated clients are earning $150 per week or more (from 26 percent in Fiscal Year 1978 to 30 percent in Fiscal Year 1980), but much of this gain may be attributed to inflationary trends.

The mean weekly earnings at closure for persons rehabilitated in Fiscal Year 1980, *exclusive* of homemakers and unpaid family workers, was $149 or 6.9 percent more than Fiscal Year 1979's rehabilitated wage-earners earned at closure. In turn, the $139 earned at closure by wage-earners in Fiscal Year 1979 was 8.7 percent more than the comparable mean earnings for persons rehabilitated in Fiscal Year 1978. These two percentage increases, 6.9 percent and 8.7 percent, did not keep pace with the increase in the Consumer Price Indices between Calendar Years 1979 and 1980 and Calendar Years 1978 and 1979 of 13.5 percent and 11.3 percent, respectively. A partial explanation would be the increase in placements into sheltered employment which is typically paid at low wage rates.

Caseload Trends Through Fiscal Year 1982

INTRODUCTION

Fiscal Year 1982 was a year in which the number of persons in State agency caseloads, as measured in a variety of ways, continued to decrease and, in most instances, decrease sharply. Compared to Fiscal Year 1981, fewer persons applied for services, fewer were accepted for services, fewer were rehabilitated and served, and fewer were still in receipt of services as Fiscal Year 1982 ended. Even cases of severely disabled persons were not spared from the overall decline, although their losses were not as steep as those for the non-severely disabled population. The severely disabled continued to account for increasing proportions of clients in State agency caseloads. In terms of total caseload volumes, the State-Federal program is no larger than it was about 12 to 14 years ago. For caseloads of severely disabled persons, volumes in Fiscal Year 1982 resembled those five years earlier.

REHABILITATIONS

In Fiscal Year 1982, 226,924 disabled persons were vocationally rehabilitated in the State-Federal program. This result represented (a) a decline of 11.3 percent from the 255,881 rehabilitations attained in Fiscal Year 1981, (b) the fewest successful closures in 14 years, and (c) the seventh decline in the last eight years following the peak performance of 361,138 rehabilitations in Fiscal Year 1974.

Rehabilitations of severely disabled persons in Fiscal Year 1982 numbered 129,866. This accomplishment represented (a) a loss of 6.2 percent from the 138,380 rehabilitations effected in Fiscal Year 1981, (b) the fewest such successes in five years, and (c) the third year in a row of a decline in this key target group of disabled persons after a high of 143,375 rehabilitations was reached in Fiscal Year 1979. The percentage of all persons rehabilitated in Fiscal Year 1982 who were severely disabled rose to 57.2 percent, the highest ever recorded.

PERSONS SERVED

In Fiscal Year 1982, there were 958,537 persons who received vocational rehabilitation services. This finding represented (a) a decline of 7.7 percent from the 1,038,232 persons served in Fiscal Year 1981, (b) the smallest such number recorded in the last 12 years, (c) the first time in 12 years that the number served fell below one million persons, and (d) the seventh decline in as many years since the high point of 1,244,338 persons served was reached in Fiscal Year 1975.

The number of severely disabled persons served totalled 571,542 in Fiscal Year 1982. This was (a) 4.9 percent below the total of 600,727 for the prior fiscal year, (b) the fewest served in five years and (c) the third consecutive decline in as many years after a high of 611,994 was established in Fiscal Year 1979. Of all persons served in Fiscal Year 1982, 59.6 percent were severely disabled, the highest such proportion recorded.

NEW APPLICATIONS FOR SERVICES

The number of persons newly applying for rehabilitation services was 564,443 in Fiscal Year 1982. This was (a) a loss of 11.6 percent from the 638,542 new applicants the year before, (b) the fewest number of new applicants in 14 years and (c) the sixth decline in the last seven years after the all-time high of 885,737 was experienced in Fiscal Year 1975.

ACCEPTANCES FOR SERVICES

The number of persons accepted for vocational rehabilitation services in Fiscal Year 1982 was 333,639. This was (a) a loss of 10.5 percent from the 373,310 newly accepted clients in the prior year, (b) the fewest number accepted into the program since Fiscal Year 1968, and (c) the sixth time in the last seven years of a decreasing trend after a high of 534,491 acceptances occurred in Fiscal Year 1975.

Severely disabled persons among those newly accepted for services totalled 200,601 in Fiscal Year 1982. This was (a) a loss of 10.6 percent from the 224,309 acceptances in the previous year, (b) the fewest number of new active cases recorded in the seven years for which data are available and (c) the third consecutive decrease after a high of 226,287 acceptances occurred in Fiscal Year 1979. The proportion of new active cases that were of severely disabled persons remained at 60.1 percent for the second year in a row.

APPLICANTS STILL IN PROCESS

The number of applicants whose eligibility for services was still being evaluated as of September 30, 1982 was 232,245. This represented (a) a decrease of 9.8 percent from the 257,610 persons in evaluation on the same date one year earlier, (b) the fewest number of end-of-year applicants in 13 years and (c) the fifth decline in the last seven years after the highest backlog of applicants of 357,653 was attained at the end of Fiscal Year 1975.

CLIENTS STILL RECEIVING REHABILITATION SERVICES

The number of persons still in receipt of rehabilitation services on September 30, 1982 was 589,038. This represented (a) a loss of 5.7 percent from the 624,669 persons receiving services on September 30, 1981, (b) the fewest number of end-of-year cases in 12 years and (c) the seventh consecutive decline since the highest backlog of 778,448 persons still receiving services was reached at the end of Fiscal Year 1975.

The number of severely disabled persons still receiving services on September 30, 1982 was 351,109. This was (a) a decrease of 4.3 percent from the 366,885 severely disabled persons in receipt of services on the same date one year earlier, (b) the fewest number of end-of-year cases in six years and (c) the third reduction in a row since the highest backlog of 381,078 cases of severely disabled persons occurred at the end of Fiscal Year 1979.

CAUSES OF CASELOAD DECLINES

The declines in caseload volumes in recent years are attributed to (a) decreases in the purchasing power of the rehabilitation dollar including the near total loss of funding from Social Security monies in Fiscal Year 1982 and (b) continued emphasis in providing services to the severely disabled for whom rehabilitation efforts are more costly. It is estimated that the purchasing power of funds available to State rehabilitation agencies declined by 31.0 percent in the relatively short period from 1979 to 1982. In dollar terms, the loss was approximately $384 million. (In actual as opposed to constant dollars, the loss was only $103 million, or 8.3 percent.) Of the $384 million decrease in purchasing power between 1979 and 1982, $209 million is attributed to the impact of inflation on Federal and State monies expended under Basic Support, and $175 million to the cutoff of funding from Social Security and a small Innovation and Expansion grant program. It was subsequent to Fiscal Year 1979 that numbers of severely disabled persons accepted into, rehabilitated by, and served by the rehabilitation program began to decline.

Table 1

Selected Caseload Volumes: Fiscal Year 1982 vs. Fiscal Year 1981 and All-Time High

Caseload Measure	Fiscal Year		Percent change: 82 vs. 81	All Time High		
	1982	1981		Fiscal Year	Number	Percent change: 82 vs. high
Total applicants	821,332	934,209	-12.1%	1975	1,204,262	-31.8%
New applicants	564,443	638,542	-11.6	1975	885,737	-36.3
Applicants on hand, end of year	232,245	257,610	- 9.8	1975	357,653	-35.1
Total active cases served	958,537	1,038,232	- 7.7	1975	1,244,338	-23.0
New active cases	333,439	373,310	-10.7	1975	534,491	-37.5
Rehabilitations	226,924	255,881	-11.3	1974	361,138	-37.2
Non-rehabilitations	142,575	157,682	- 9.6	1976	179,139	-20.4
Active cases on hand, end of year	589,038	624,669	- 5.7	1975	778,448	-24.3
Severe active cases served	571,542	600,727	- 4.9	1979	611,994	- 6.6
New severe active cases	200,601	224,309	-10.6	1979	226,287	-11.4
Severe rehabilitations	129,866	138,380	- 6.2	1979	143,375	- 9.4
Severe non-rehabilitations	90,567	95,462	- 5.1	1981	95,462	- 5.1
Severe active cases on hand, end of year	351,109	366,885	- 4.3	1979	381,078	- 7.9

FIGURE 1

NUMBER OF PERSONS REHABILITATED AND NOT REHABILITATED, AND REHABILITATION RATES, FY 1972 - FY 1982

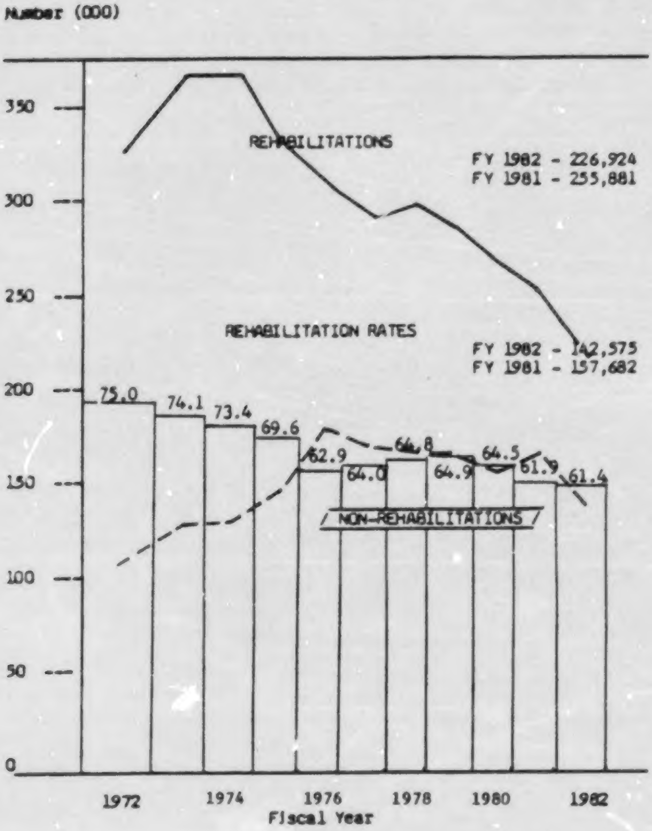

FIGURE 2

SEVERELY AND NON-SEVERELY DISABLED PERSONS
REHABILITATED, FY 1974 - FY 1982

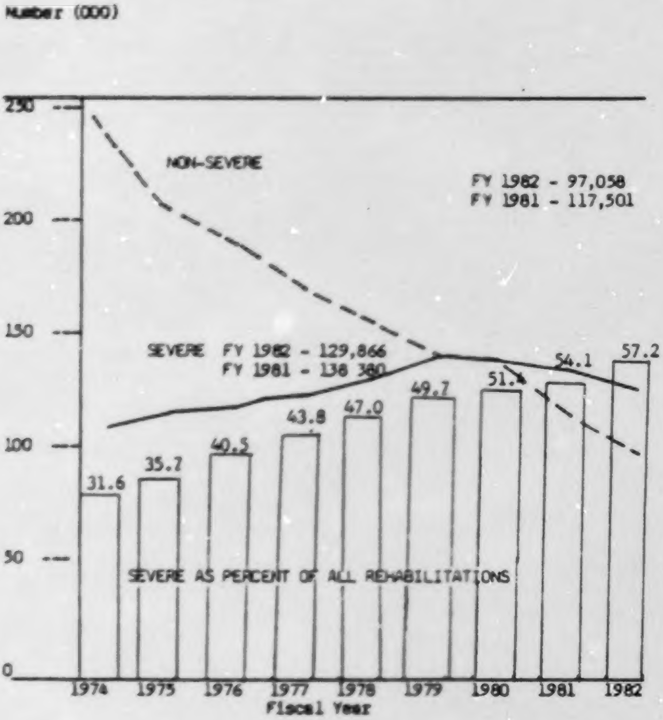

FIGURE 3

SEVERELY AND NON-SEVERELY DISABLED PERSONS:
ACTIVE CASES SERVED, FY 1976 - FY 1982

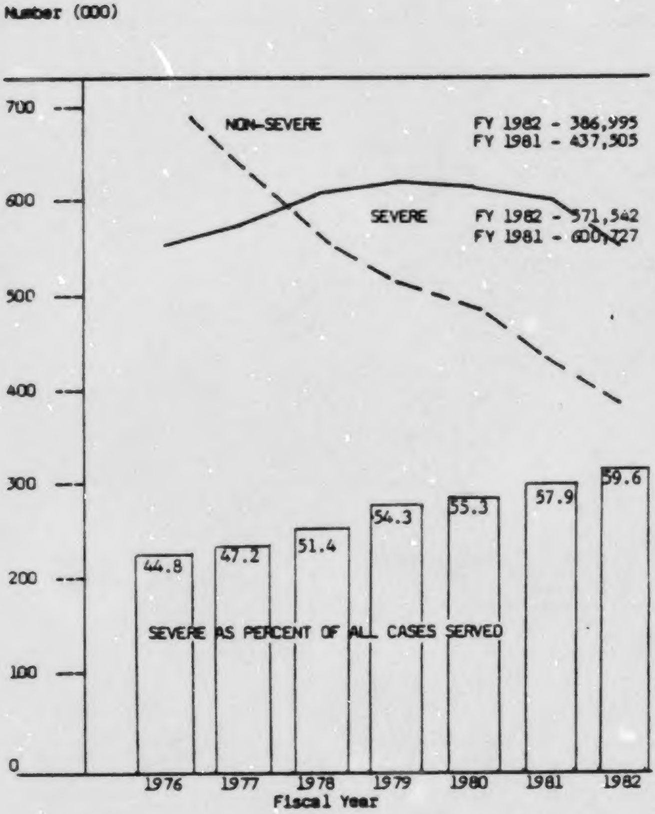

FIGURE 4

NEW APPLICANTS AND NEW ACTIVE CASES
DURING FY 1972 - FY 1982

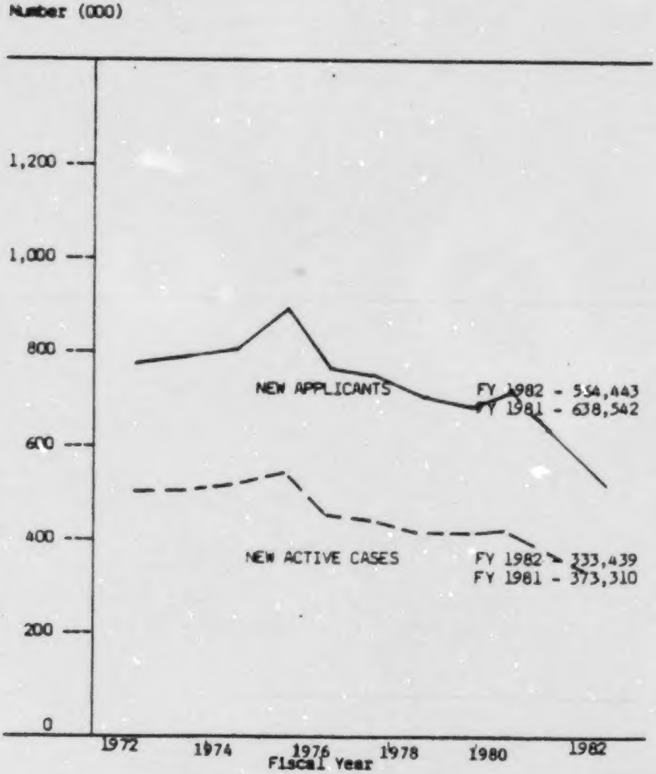

FIGURE 5

NUMBER OF APPLICANTS ACCEPTED AND NOT ACCEPTED
FOR VOCATIONAL REHABILITATION SERVICES,
AND ACCEPTANCE RATES, FY 1972 - FY 1982

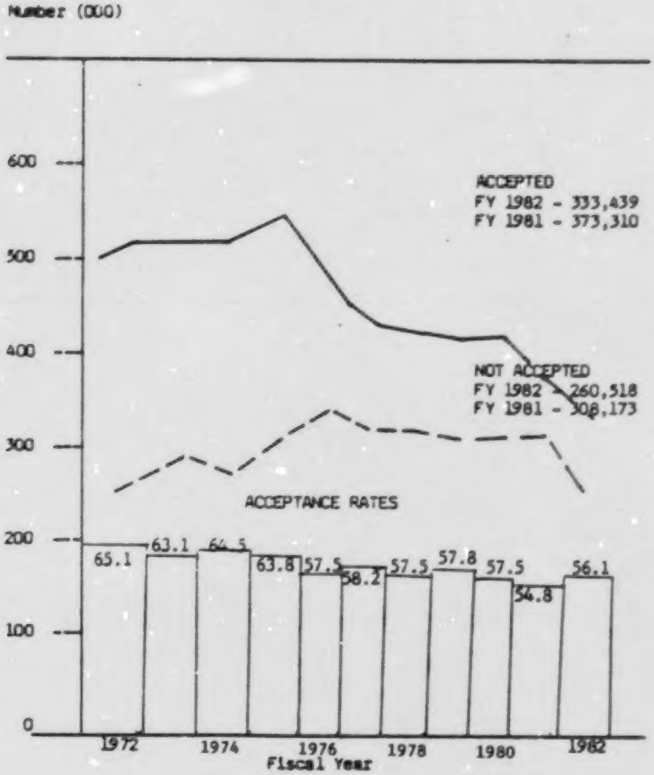

Table 1. — Number of cases in caseloads of State vocational rehabilitation agencies during Fiscal Years 1972 - 1982

Fiscal Year	Applicants and Active Cases		Active Caseload Only	
	Number of Cases (Statuses 02-30)	Percent Change From Previous Year	Number of Cases (Statuses 10-30)	Percent Change From Previous Year
1982	1,473,313	- 9.7	958,537	- 7.7
1981	1,631,167	- 5.7	1,038,232	- 5.2
1980	1,728,987	- 1.3	1,095,139	- 2.9
1979	1,751,862	- 3.5	1,127,551	- 3.5
1978	1,815,564	- 2.7	1,167,991	- 3.0
1977	1,866,707	- 3.0	1,204,487	- 2.7
1976	1,925,049	- 0.7	1,238,446	- 0.5
1975	1,937,872	+ 5.2	1,244,338	+ 3.6
1974	1,824,545	+ 6.2	1,201,661	+ 2.1
1973	1,798,132	+ 5.4	1,176,445	+ 5.9
1972	1,706,710	+ 9.9	1,111,045	+10.9

Table Number of active cases served and persons rehabilitated by State vocational rehabilitation agencies, Fiscal Years 1921 - 1982

Fiscal Year	Cases Served	Persons Rehabilitated	Fiscal Year	Cases Served	Persons Rehabilitated
1982	958,537	226,924			
1981	1,038,232	255,881	1951	231,544	66,193
1980	1,095,139	277,136	1950	255,724	59,597
1979	1,127,551	288,325	1949	216,997	58,020
1978	1,167,991	294,396	1948	191,063	53,131
1977	1,204,487	291,202	1947	170,143	43,880
1976	1,238,446	303,328	1946	169,796	36,106
1975	1,244,338	324,039	1945	161,050	41,925
1974	1,201,661	361,138	1944	145,059	43,997
1973	1,176,445	360,726	1943	129,207	42,618
1972	1,111,045	326,138	1942	91,572	21,757
1971	1,001,660	291,272	1941	78,320	14,579
1970	875,911	266,975	1940	65,624	11,890
1969	781,614	241,390	1939	63,575	10,747
1968	680,415	207,918	1938	63,666 1/	9,844
1967	569,907	173,594	1937		11,091
1966	499,464	154,279	1936		10,338
1965	441,332	134,859	1935		9,422
1964	399,852	119,708	1934		8,062
1963	368,696	110,136	1933		5,613
1962	345,635	102,377	1932		5,592
1961	320,963	92,501	1931		5,184
1960	297,950	88,275	1930		4,605
1959	280,384	80,739	1929		4,645
1958	258,444	74,317	1928		5,012
1957	238,582	70,940	1927		5,092
1956	221,128	65,640	1926		5,604
1955	209,039	57,981	1925		5,825
1954	211,219	55,825	1924		5,654
1953	221,849	61,308	1923		4,530
1952	228,490	63,632	1922		1,898
			1921		523

1/ Data prior to 1938 not available

Table 3 -- Number of persons rehabilitated and not rehabilitated by State vocational rehabilitation agencies, Fiscal Years 1972 - 1982

Fiscal Year	Persons Rehabilitated		Persons Not Rehabilitated		Rehabilitation Rate 1/
	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year	
1982	226,924	-11.3	142,575	- 9.6	61.4
1981	255,881	- 7.7	157,682	+ 3.3	61.9
1980	277,136	- 3.8	152,672	- 2.3	64.5
1979	288,325	- 2.1	156,258	- 2.2	64.9
1978	294,396	+ 1.1	159,846	- 2.4	64.8
1977	291,202	- 4.0	163,706	- 8.6	64.0
1976	303,328	- 6.4	179,139	+26.3	62.9
1975	324,039	-10.3	141,851	+ 8.4	69.6
1974	361,138	+ 0.1	130,871	+ 3.9	73.4
1973	360,726	+10.6	125,991	+15.8	74.1
1972	326,138	+12.0	108,784	+12.5	75.0

1/ Rehabilitation rates show the number of persons rehabilitated as a percent of all active case closures, whether rehabilitated or not.

Table 6 — Number of applicant and extended evaluation cases accepted and not accepted for VR services by State vocational rehabilitation agencies, Fiscal Years 1972 - 1982

Fiscal Year	Persons Accepted		Persons Not Accepted		Acceptance Rate 1/
	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year	
1982	333,430	-10.7	260,518	-15.5	56.1
1981	373,310	- 9.5	308,173	+ 1.2	54.8
1980	412,396	+ 0.2	304,525	+ 1.1	57.5
1979	411,560	- 1.9	301,077	- 2.8	57.8
1978	419,390	- 3.6	309,624	- 0.9	57.5
1977	435,144	- 5.3	312,515	- 7.9	58.2
1976	459,620	-14.0	339,494	+12.1	57.5
1975	534,681	+ 4.6	302,942	+ 7.7	63.8
1974	511,226	+ 1.6	281,376	- 4.4	64.5
1973	503,318	+ 1.3	294,271	+10.5	63.1
1972	496,880	+ 6.1	266,312	+ 8.0	65.1

1/ Acceptance rates show the number of cases accepted for VR services as a percent of all applicant and extended evaluation cases accepted and not accepted.

Table 5 -- Number of new applicants, new extended evaluation cases and new active cases in the caseloads of State vocational rehabilitation agencies during Fiscal Years 1972 - 1982

Fiscal Year	New Applicants (Status 02)		New Extended Evaluation Cases (Status 06)		New Active Cases (Status 10)	
	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year
1982	564,443	-11.6	28,778	-18.3	333,439	-10.7
1981	638,542	-11.7	35,224	-15.0	373,310	- 9.5
1980	722,847	+ 3.6	41,426	+ 1.5	412,356	+ 0.2
1979	697,873	- 2.4	40,843	- 1.0	411,560	- 1.9
1978	715,367	- 4.2	41,240	- 1.7	419,590	- 3.6
1977	746,377	- 2.3	41,948	+ 8.1	435,144	- 5.3
1976	763,714	-13.8	38,792	- 7.3	459,620	-14.0
1975	885,737	+ 9.9	41,848	+28.5	534,491	+ 4.6
1974	806,000	+ 1.2	32,556	+ 6.8	511,226	+ 1.6
1973	796,116	+ 1.3	30,486	+ 6.6	503,318	+ 1.3
1972	786,117	+ 7.8	28,587	+12.0	496,680	+ 6.1

Number of applicant, extended evaluation and active cases remaining at the end of the fiscal year in caseloads of State vocational rehabilitation agencies, Fiscal Years 1972 - 1982

Fiscal Year	Total cases remaining (Statuses 02 - 24)		In applicant status (Status 02)		In extended evaluation (Status 06)		In active statuses (Statuses 10 - 24)	
	Number	Percent change from previous year	Number	Percent change from previous year	Number	Percent change from previous year	Number	Percent chan from previou year
1982	843,301	- 7.3	232,245	- 9.8	22,013	-18.9	589,038	- 5.7
1981	909,431	- 8.6	257,610	-13.3	27,152	-15.6	624,669	- 6.1
1980	994,654	- 1.1	297,148	+ 1.9	32,175	+ 2.2	665,331	- 2.6
1979	1,006,202	- 4.3	291,730	- 4.5	31,504	- 2.9	682,968	- 4.3
1978	1,051,698	- 4.3	305,514	- 3.5	32,435	- 1.8	713,749	- 4.8
1977	1,099,284	- 0.3	316,662	+ 0.4	33,043	+ 4.7	749,579	- 0.8
1976	1,103,088	- 5.6	315,549	-11.8	31,560	- 4.2	755,979	- 2.9
1975	1,169,040	+ 1.1	357,653	+12.4	32,939	+41.9	778,448	+ 9.7
1974	1,051,160	+ 3.3	318,297	+ 4.1	23,211	+ 7.9	709,652	+ 2.9
1973	1,017,144	+ 1.2	305,902	- 0.8	21,514	+ 5.3	689,728	+ 2.0
1972	1,004,876	+ 9.6	308,331	+ 8.0	20,422	+12.8	676,123	+10.2

Table 1

Selected Caseload Volumes: Fiscal Year 1982 vs. Fiscal Year 1981 and All-Time High

Caseload Measure	Fiscal Year		Percent change: 82 vs. 81	All Time High		
	1982	1981		Fiscal Year	Number	Percent change: vs. hi
Total applicants	821,332	934,209	-12.1%	1975	1,204,262	-31.
New applicants	564,443	638,542	-11.6	1975	885,737	-36.
Applicants on hand, end of year	232,245	257,610	- 9.8	1975	357,653	-35.
Total active cases served	958,537	1,038,232	- 7.7	1975	1,244,338	-23.
New active cases	333,439	373,310	-10.7	1975	534,491	-37.
Rehabilitations	226,924	255,881	-11.3	1974	361,138	-37.
Non-rehabilitations	142,575	157,682	- 9.6	1976	179,139	-20.
Active cases on hand, end of year	589,038	624,669	- 5.7	1975	778,448	-24.
Severe active cases served	571,542	600,727	- 4.9	1979	611,994	- 6.
New severe active cases	200,601	224,309	-10.6	1979	226,287	-11.
Severe rehabilitations	129,866	138,380	- 6.2	1979	143,375	- 9.
Severe non-rehabilitations	90,567	95,462	- 5.1	1981	95,462	- 5.
Severe active cases on hand, end of year	351,109	366,885	- 4.3	1979	381,078	- 7.

Table 6 - Number of persons rehabilitated and served by State vocational rehabilitation agencies per 100,000 population, 1/ Fiscal Years 1971-1982

Fiscal Year	Resident Population 2/(mil)	Rehabilitations		Active Cases Served	
		Number 3/	Rate per 100,000 population	Number 3/	Rate per 100,000 population
1982	229.3	222,940	97	936,543	409
1981	227.2	251,483	110	1,014,518	447
1980	224.6	272,204	121	1,059,853	476
1979	222.1	283,185	127	1,101,015	496
1978	219.8	289,531	132	1,141,024	519
1977	217.6	286,906	132	1,177,993	541
1976	215.5	297,147	138	1,209,791	561
1975	213.3	319,251	149	1,214,585	570
1974	211.4	355,528	168	1,172,906	555
1973	209.3	355,614	170	1,150,772	550
1972	206.8	321,612	156	1,089,825	527
1971	204.0	288,158	141	984,982	483

1/ Rates are based on the estimated total resident population on July 1 of each fiscal year except for Fiscal Years 1971 and 1981 which are based on the Decennial Census as of April 1, 1970 and 1980, respectively. Source: U.S. Bureau of the Census, "Current Population Reports," series P-25, Nos. 802 and 903.

2/ Resident population does not include information from Puerto Rico or any of the outlying territories.

3/ Excludes data from Puerto Rico, Virgin Islands, Guam, American Samoa, Trust Territories of the Pacific Islands and Northern Mariana Islands.

Table 8. -- Number of applicant, extended evaluation and active cases in State vocational rehabilitation agencies, percent change and percent distribution, Fiscal Years 1981 - 1982

Caseload item	Fiscal Year		Percent Change	Percent distribution	
				Fiscal Year	
	1982	1981		1982	1981
Applicants (02)					
Number available	821,332	934,209	-12.1	100.0	100.0
On hand, Oct. 1	256,889	295,667	-13.1	31.3	31.6
New since Oct. 1	564,443	638,542	-11.6	68.7	68.4
Number processed	589,087	676,599	-12.9	71.7	72.4
Accepted for VR (10)	317,461	354,041	-10.3	38.7	37.9
Accepted for EE (06)	28,778	35,224	-18.3	3.5	3.8
Not accepted for VR or EE (08)	242,848	287,334	-15.5	29.6	30.7
Total on hand, Sept. 30	232,245	257,610	- 9.8	28.3	27.6
Extended evaluation cases (06)					
Number available	55,661	67,260	-17.2	100.0	100.0
On hand, Oct. 1	26,883	32,036	-16.1	48.3	47.6
New since Oct. 1	28,778	35,224	-18.3	51.7	52.4
Number processed	33,648	40,108	-16.1	60.5	59.6
Accepted for VR (10)	15,978	19,269	-17.1	28.7	28.6
Not accepted for VR (08)	17,670	20,839	-15.2	31.7	31.0
Total on hand, Sept. 30	22,013	27,152	-18.9	39.5	40.4
Active cases (10-30)					
Number available 1/	958,537	1,038,232	- 7.7	100.0	100.0
On hand, Oct. 1	625,098	664,922	- 6.0	65.2	64.0
New since Oct. 1	333,439	373,310	-10.7	34.8	36.0
Number closed	369,499	413,563	-10.7	38.5	39.8
Rehabilitated (26)	226,924	255,881	-11.3	23.7	24.6
Not rehabilitated (28)	104,615	116,156	- 9.9	10.9	11.2
Not rehabilitated (30)	37,960	41,526	- 8.6	4.0	4.0
Total on hand, Sept. 30	589,038	624,669	- 5.7	61.5	60.2

1/ Active cases served.

Table 16. -- Persons rehabilitated by State vocational rehabilitation agencies and percent change from previous year, by severity of disability: Fiscal Years 1974 - 1982

A. Severely Disabled

Fiscal Year	Rehabilitations	Percent Change 1/
1982	129,866	- 6.2
1981	138,380	- 2.9
1980	142,545	- 0.5
1979	143,375	+ 3.6
1978	138,402	+ 8.5
1977	127,522	+ 3.7
1976	122,938	+ 6.3
1975	115,746	+ 1.5
1974	113,997	2/

B. Non-Severely Disabled

Fiscal Year	Rehabilitations	Percent Change 1/
1982	97,058	-17.4
1981	117,501	-12.7
1980	134,591	- 7.1
1979	144,950	- 7.1
1978	155,994	- 4.7
1977	163,680	- 9.3
1976	180,390	-13.4
1975	208,293	-15.7
1974	247,141	2/

1/ Comparison to same period of previous year.
2/ Data not available.

Table 17. -- Total, Severely and Non-Severely Disabled Cases Rehabilitated by State Vocational Rehabilitation Agencies and Percent Severe, Fiscal Years 1974-1982

Fiscal Year	Total	Severely Disabled	Non-Severely Disabled	Percent Severe 1/
1982	226,924	129,866	97,058	57.2
1981	255,881	138,380	117,501	54.1
1980	277,136	142,545	134,591	51.4
1979	288,325	143,375	144,950	49.9
1978	294,386	138,402	155,984	47.0
1977	291,202	127,522	163,680	43.8
1976	303,328	122,938	180,390	40.5
1975	324,039	115,746	208,293	35.7
1974	361,138	113,997	247,141	31.6

Table 18. -- Rehabilitation Rate for Severely and Non-Severely Disabled Clients of State Vocational Rehabilitation Agencies, Fiscal Years 1976 - 1982

Fiscal Year	Rehabilitation Rate 2/		
	Total	Severe	Non-Severe
1982	61.4	58.9	65.1
1981	61.9	59.2	65.2
1980	64.5	60.9	68.7
1979	64.9	62.1	67.8
1978	64.8	62.5	67.0
1977	64.1	61.4	66.3
1976	62.9	60.0	65.0

1/ Severe as a percent of severe and non-severe cases.

2/ Rehabilitations ÷ (All active cases closed).

REHABILITATION ACT: SUBCOMMITTEE EXPLANATION OF FUNDING RECOMMENDATION

WHY IS THE INCREASE IN STATE GRANTS PARTICULARLY NEEDED RIGHT NOW?

At a time when unemployment is seriously affecting millions of Americans, disabled Americans are suffering even more.

- --The unemployment rate among disabled persons who are able to work is more than 50% --a conservative estimate.
- --State rehabilitation agencies are able to serve only about one out of every 20 eligible clients.

HOW DID YOU ARRIVE AT A $1037.8 FUNDING RECOMMENDATION FOR STATE GRANTS?

This a 9.95% increase. Over a four year period, increases of this percentage will bring the level of funding to its FY 1979 equivalent in purchasing power.

WHY IS RESTORATION TO THE FY 1979 FUNDING EQUIVALENT AN APPROPRIATE OBJECTIVE?

Although the decline in overall service levels by the states--in both severely disabled and non-severely disabled cases--began in 1975, it might be argued that prior to 1979 the decline represents a shift in resources to more expensive severely disabled cases. Since 1979, however, the drop in both severely and non-severely disabled cases shows a clear decline in the states' ability to serve eligible applicants.

- --Since 1979 the actual number of severely disabled persons states are rehabilitating has declined by 10%.

WHY IS IT IMPORTANT TO PROVIDE THE STATES THE RESOURCES TO SERVE THE SEVERELY DISABLED?

Although it is more costly to serve the severely disabled, the cost/benefits to the government are far greater. According to Rehabilitation Services Administration studies, the severely disabled are more dependent on public support and much less likely to find employment without rehabilitation services than are the non-severely disabled.

WHAT DATA ILLUSTRATE THE DECLINE IN REHABILITATION SERVICES DURING THE RECENT PAST?

Between 1979 and 1982 there was a 31% loss in purchasing power.

--In terms of dollars, the purchasing power loss was $384 million.

--$209 million represents loss due to inflation

--$175 million represents loss due to cuts in funding through the SSI and SSDI rehabilitation program and cuts in the innovation and expansion grants part of the Rehabilitation Act.

States' all-time high in rehabilitations was in 1974.

--Between 1974 and 1982 there was a 37.2% drop in number of rehabilitations.

In 1982, cases served dropped below one million for the first time in 12 years.

In 1982, rehabilitations were the lowest in 14 years.

WHAT DATA ILLUSTRATE THE COST/EFFECTIVENESS OF THE PROGRAM?

Most recent data from RSA shows that in the first year after case closure, persons rehabilitated paid $211.5 million more in income, payroll and sales taxes than they would have paid without rehabilitation. Another $68.9 million was saved as a result of decreased dependency on public support payments and institutional care. In just one year, the benefits to governments was $280.4 million. In four years the entire cost of the rehabilitations was returned.

The lifetime earnings of disabled persons is increased by $10 for every one dollar spent on their rehabilitation.

WHAT DOES CBO SAY ABOUT THE IMPORTANCE OF INVESTMENT IN REHABILITATING THE DISABLED?

In a letter dated May 8, 1981, Alice Rivlin, CBO Director, wrote: "Since expenditures for vocational rehabilitation are associated with offsetting savings in other government programs, a reduction in funding for rehabilitation... would generate increases in other parts of the federal and state budgets."

April 1983

RECOMMENDATIONS OF THE REHABILITATION COALITION
WITH RESPECT TO
FY 1984 APPROPRIATIONS
FOR PROGRAMS AUTHORIZED UNDER THE REHABILITATION ACT OF 1973

The Rehabilitation Coalition* consists of national organizations representing rehabilitation professionals, institutions, consumers, and others who are concerned with strengthening the vocational rehabilitation program and improving the lives and opportunities of persons with disabilities.

The Rehabilitation Coalition views the Rehabilitation Act of 1973, as amended, as one of the most complete and well-balanced pieces of legislation in the human services field. The Program of Vocational Rehabilitation is a cornerstone in the governmental effort, at both the federal and state levels, to assist disabled Americans. In one Act, provisions are included for a comprehensive and individually-tailored program of services to physically and mentally disabled persons, a training program, a research program, a special projects program, a comprehensive services program for independent living, and other specially targeted programs.

With its focus of rehabilitating people with mental and physical disabilities to employment and self-sufficiency, the Rehabilitation Program has served many millions of disabled individuals, and has rehabilitated and placed over five million people into meaningful, productive jobs during its 63 years of existence, making it one of the most cost-effective programs in our nation's history. These comprehensive rehabilitation services are provided by and through State Rehabilitation Agencies, often through cooperative agreements and contracts with other public and private, nonprofit, community-based organizations and facilities.

People with disabilities comprise a significant portion of the nation's population; 35 million is the estimate. The size of the disabled population is not static, but continues to grow through accidents, injuries, illnesses, and birth defects at an estimated rate of 500,000 annually. Of the total population, approximately 10 million people may be categorized as severely disabled.

The Rehabilitation Program signifies the nation's recognition of its responsibility to provide disabled citizens with the opportunity to be a part of the mainstream of life as full participants.

The information contained on the attached pages outlines more specifically the unique needs served by each aspect of the Rehabilitation Program. Also provided are justifications for the provision of funds for each of these vital programs.

* Members of the Rehabilitation Coalition are listed on the following page.

The following members of the Rehabilitation Coalition endorse the recommendations contained in this document:

American Academy of Physical Medicine and Rehabilitation
American Association of Workers for the Blind
American Coalition of Citizens with Disabilities
American Congress of Rehabilitation Medicine
American Council of the Blind
American Deafness and Rehabilitation Association
American Foundation for the Blind
American Occupational Therapy Association
American Physical Therapy Association
Association for Retarded Citizens
Conference of Educational Administrators Serving the Deaf
Convention of American Instructors of the Deaf
Council for Exceptional Children
Council of State Administrators of Vocational Rehabilitation
Epilepsy Foundation of America
Goodwill Industries of America
National Association of the Deaf
National Association of Private Residential Facilities for
  the Mentally Retarded
National Association of Rehabilitation Facilities
National Association of Rehabilitation Research and Training Centers
National Association of State Mental Health Program Directors
National Council on Rehabilitation Education
National Council of State Agencies for the Blind
National Easter Seal Society
National Multiple Sclerosis Society
National Rehabilitation Association
National Society for Children and Adults with Autism
Paralyzed Veterans of America (non-member of Coalition)
State Mental Retardation Program Directors Association
United Cerebral Palsy Associations, Inc.
American Assn on Mental Deficiency

For further information, contact:

The Rehabilitation Coalition
738 9th Street, S.E.
Washington, DC 20003

232-6963 / 785-3388

VOCATIONAL REHABILITATION STATE GRANTS

APPROPRIATIONS FY 81	APPROPRIATIONS FY 82	APPROPRIATIONS FY 83	FY 1984 AUTHORIZATION	PRESIDENT'S FY 84 REQUEST	COALITION RECOMMENDATION
854.259	863.04	943.9	PENDING	943.9	1,037.8

(in millions)

PROGRAM DESCRIPTION: The State-Federal Rehabilitation Program begins its 63rd year of providing comprehensive services to persons with mental and physical disabilities. Authorized by Section 110 of the Rehabilitation Act of 1973, as amended, this Program continues as the focus of our Nation's effort to assist disabled Americans in their efforts to become gainfully employed.

According to government projections and statistics, this program is a proven, cost-effective, and cost-efficient method of providing vital services to persons with disabilities. Regardless, the purchasing power of the "rehabilitation dollar" has been weakened over the past years due to inflation and suppressed funding. Furthermore, due to the decrease in funds available to the States through Social Security Vocational Rehabilitation Programs, from approximately $124 million in FY 1981 to approximately $3 million in FY 1982, the State Rehabilitation Agencies were unable to provide services to approximately 110,000 persons.

IMPACT OF ADMINISTRATION'S PROPOSALS: The Administration is requesting that Federal funding for Section 110 be "frozen" at the FY 1983 level of $943.9 million. The effect of this proposal will be:

- The continued weakening of the purchasing power of the rehabilitation dollar.
- The continued decline in the number of persons served and the number rehabilitated into employment.
- The continued lessening of additional resources for the rehabilitation of beneficiaries of SSDI and SSI, due to the minimal increases in the Administration's request for funding for these programs.

REHABILITATION COALITION RECOMMENDATION: The Rehabilitation Coalition recommends that the Congress appropriate $1,037.8 million for the funding of grants to the States for the provision of Rehabilitation Services to persons with mental and physical disabilities, in FY 1984.

JUSTIFICATION: This recommendation, if appropriated by the Congress, would in part achieve the goal of restoring the purchasing power of the "rehabilitation dollar" to the 1979 Section 110 Federal spending level. Increases would have to be made over the next four fiscal years to fully achieve this goal.

FY 1979 is viewed as the last year in which the State-Federal Rehabilitation program operated at full strength. Ever since that year, there has been a steady decline in the number and type of persons with disabilities served, due to economic and programmatic factors.

In this time of historically high unemployment, it must be remembered that there is no group in our society experiencing more unemployment than that experienced by persons with disabilities. This program is the only major Federal effort geared fully towards the goal of gainful employment for persons with disabilities.

REHABILITATION TRAINING

APPROPRIATIONS			FY 1984	PRESIDENT'S	COALITION
FY 81	FY 82	FY 83	AUTHORIZATION	FY 84 REQUEST	RECOMMENDATION
21.60	19.20	19.20	pending	19.20	25.50

(in millions)

PROGRAM DESCRIPTION AND NEED: The Rehabilitation Training Program supports training in all of the professional disciplines related to rehabilitation including medicine, physical therapy, occupational therapy, speech-language pathology and audiology, rehabilitation counseling, rehabilitation facility administration, interpreters for the deaf, and personnel to serve the blind. Approximately one-fourth of its budget is spent on in-service training and related short-term training and continuing education programs. Support for the rehabilitation training program has decreased dramatically over the past five years. The current funding level is only $19.2 million, whereas the program received $30.4 million in FY 1977-78.

Evidence of manpower shortages accumulated through vari us studies shows the need for additional rehabilitation professionals.

o The Congressionally mandated analysis of rehabilitation manpower needs, completed by RSA, found major shortages throughout the rehabilitation field in medicine, prosthetics and orthotics, rehabilitation counseling, physical therapy, occupational therapy, and speech-language pathology.

o The Graduate Medical Education National Advisory Committee (GMENAC) has found, generally, a surplus of physicians but nearly a 100% shortage of physicians in rehabilitation medicine.

o A 1980 Bureau of Labor Statistics' Report indicates a need for 65% more occupational therapists, 53% more physical therapists, and 47% more speech-language pathologists and audiologists during the 1980s.

Vocational rehabilitation is a team effort of rehabilitation and vocational experts. Efficient and effective rehabilitation occurs only when an adequate supply of all team members is available.

IMPACT OF PRESIDENT'S 1984 BUDGET REQUEST: The Administration has proposed that the FY 84 Rehabilitation Training budget be frozen at the FY 83 level of $19.2 million. This would be the third consecutive year that training funds have been frozen, which would represent a real reduction of nearly 20% from the FY

81 appropriation of $21.68 million. The Department of Education estimates that at $19.2 million, approximately 6% fewer rehabilitation personnel would be trained in FY 84 than in FY 83. Yet major personnel shortages have been documented in many of the rehabilitation professions.

REHABILITATION COALITION RECOMMENDATION: The Rehabilitation Coalition recommends an appropriation of $25.5 million, which is equal to last year's FY 83 authorization level.

JUSTIFICATION: Due to advances in life saving techniques, many more persons are surviving trauma and illness, increasing the need for rehabilitation services. In FY 1981 a little over one million clients were served by the Department of Vocational Rehabilitation. In the same year almost one-half million eligible clients were turned away. At the same time graduates in many allied health fields have leveled off due to reductions in federal training support. Technological advances in the field of rehabilitation necessitate a highly trained team to provide services. Additional training funds are needed just to slightly increase the graduates in rehabilitation.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

APPROPRIATIONS FY 81	APPROPRIATIONS FY 82	APPROPRIATIONS FY 83	FY 1984 AUTHORIZATION	PRESIDENT'S FY 84 REQUEST	COALITION RECOMMENDATION
18.0	17.28	17.28	pending	17.28	45

(in millions)

PROGRAM DESCRIPTION: Title VII of the Rehabilitation Act of 1973, as amended, authorizes several different approaches to promoting independent living services, particularly to persons too severely disabled to qualify for Vocational Rehabilitation. The 1978 amendments to the Act envisioned a major statewide service delivery system, "Comprehensive Services for Independent Living," in Part A. However, the Administration and Congress have restricted the program to the federally administered Part B Centers for Independent Living.

IMPACT OF THE PRESIDENT'S 1984 BUDGET REQUEST: For the first time in the President's three budget submissions, the Administration has proposed level funding for the (Part B) Independent Living (IL) program. No funding is requested for Part A.

The President's budget request would permit continued operation of the approximately 150 centers currently operating with at least one in each of the 50 states. However, level funding since FY 1982 would require the centers to continue to reduce their level of operation to reflect the impact of inflation over the past two years.

REHABILITATION COALITION RECOMMENDATION: For the first year of operation, P.L. 95-602, the 1978 authorizing statute, earmarked $80 million for Parts A, B and C (older blind persons set-aside). The Rehabilitation Coalition recommends an appropriation of $45 million and urges Congress to reauthorize Parts A, B and C. The $45 million would allow $25 million to initiate Part A, $18 million to maintain Part B and $2 million to initiate Part C.

JUSTIFICATION: The primary concern of the Rehabilitation Coalition with the Independent Living program is how to create a transition from a federally administered series of model and demonstration centers which have proved their value to a statewide service delivery system for the severely disabled population. A key factor to implementing this transition is the start-up of Part A while maintaining funding continuity for existing Part B centers.

NATIONAL INSTITUTE OF HANDICAPPED RESEARCH

APPROPRIATIONS FY 81	 FY 82	 FY 83	FY 1984 AUTHORIZATIONS	PRESIDENT'S FY 84 REQUEST	COALITION RECOMMENDATION
29.75	28.56	30.06	pending	30.06	37.5

(in millions)

PROGRAM DESCRIPTION: The Institute is responsible for research related to medical, social, psychological and vocational rehabilitation services. It is also responsible for research involving engineering related to environmental aspects of rehabilitation and equipment and devices. The statutory priorities for the Institute are support of rehabilitation research and training centers, engineering research projects and centers, spinal cord injury research, and research regarding the aged and children.

IMPACT OF THE PRESIDENT'S 1984 BUDGET REQUEST: The budget of the Institute and its predecessor program has not increased overall in the last 15 years. In constant dollars, the program has decreased by more than 50% in that period. In 1969 and 1970, $32 million was spent on rehabilitation research, whereas only $30.5 million is being spent this year and only $30.5 million is in the President's FY 1984 budget request. The President's budget only allows $3 million to $4 million for new projects in FY 1984. An additional $7.5 million above the President's budget is needed. The President's budget has no funds for new programs.

COALITION RECOMMENDATION: The Rehabilitation Coalition recommends the NIHR funding be increased to $37.5 million in FY 84 .

JUSTIFICATION: In FY 1983, 228 applications for center and project grants were submitted. Only 48, or about 22%, were funded. Eighty-six projects and centers were approved for funding if funds were available. Thirty-eight centers and projects which were approved for funding went unfunded. Twenty-seven of those received scores that were 375 or above on a scale of 1 to 500 and on the average the centers and grants funded scored at just about 400. At least two approved projects and centers which scored at very high levels went unfunded in the spinal cord injury area, the mental retardation area, and the rural service delivery area.

An additional $7.5 million above the President's budget would enable NIHR to undertake the following initiatives:

1. Establish a research training program funded at $1 million

CLIENT ASSISTANCE PROJECTS

APPROPRIATIONS FY 81	 FY 82	 FY 83	FY 1984 AUTHORIZATION	PRESIDENT'S FY 84 REQUEST	COALITION RECOMMENDATION
3.0	3.0	1.734	pending	0	3.0

(in millions)

PROGRAM DESCRIPTION: The Client Assistance Program was established in 1973, along with due process procedures, to strengthen the clients' voice in the rehabilitation process and provide the clients with a means of redress if the process was not responsive to their needs. Gradually 37 States have agreed to participate. In most States, the VR agencies have opted to run the program within the agency. Approximately five states have placed the CAP program in external independent advocacy agencies. The programs operated outside the State agencies have been particularly effective. All the projects have enabled VR clients to learn about available services and their right to them. Many have helped clients overcome barriers to the provision of services.

IMPACT OF THE PRESIDENT'S 1984 BUDGET REQUEST: The Administration has recommended a phase out of the program, with no further funding for 1984. States will be encouraged to fund the programs with existing State dollars.

o Handicapped persons in need of rehabilitation services will lose an important source of information and advocacy services which enable them to effectively use the rehabilitation services provided by Federal monies.

o The rehabilitation system will lose the one monitoring component which acts as a check on the program and assures more effective operation.

o VR clients who are not developmentally disabled (and therefore not eligible for services from the DD P&A system) will have their only advocacy resources removed.

REHABILITATION COALITION RECOMMENDATION: The Rehabilitation Coalition recommends continued funding at $3 million.

JUSTIFICATION: The recommended funding level would permit CAP agencies to provide a level of services comparable to FY 1982.

which would support about 50 research trainees and fellows. No program presently exists.

2. Establish a new $3 million program to support individual research investigators initiating their own research projects. This amount would support about 40 new investigators and 40 individual projects.

3. Fund with about $3.5 million 12 new centers and projects that were approved and unfunded with highly meritorious scores in FY 1983 or have a competition to fund the 12 new projects and centers.

It is estimated that with the same interest as FY 1983, a $7.5 million addition over the President's budget for new competition would still result in only about 30% of all approved centers and projects being funded and at scores substantially above 400. These standards are higher than those currently applicable to NIH.

These funds would enable major efforts to begin in pediatrics rehabilitation research and research related to independent living services. It would enable a major and needed expansion of activity for spinal cord injury research, mental retardation research, and research related to multiple sclerosis and arthritis.

SPECIAL PROJECTS FOR THE SEVERELY DISABLED

APPROPRIATIONS			FY 1984	PRESIDENT'S	COALITION
FY 81	FY 82	FY 83	AUTHORIZATION	FY 84 REQUEST	RECOMMENDATION
9.765	8.855	11.259	pending	10.295	12.21

(in millions)

PROGRAM DESCRIPTION: This program authorized by Sec. 311, entitled "Special Demonstration Programs," is often referred to by the two operative programs it encompasses: "Special Projects for the Severely Disabled" and "Regional Spinal Cord Injury Centers." The Special Projects are focused on VR projects concerning blindness, deafness, mental illness, epilepsy, cerebral palsy, multiple sclerosis, mental retardation, arthritis, learning disability, deaf/blind and other broader disability focuses on Hispanic access, general severe disability and telecommunications.

These demonstration projects and centers are developing improved VR service models and paving the way for State Agencies to build into their systems more efficient and successful programs to serve severely disabled persons from currently "underserved populations."

IMPACT OF THE PRESIDENT'S 1984 BUDGET REQUEST: Because of the possible reallocation of funds from Discretionary Service Projects to Independent Living Centers to fulfill the Congressional mandate to continue funding those Centers which received funding in FY 1981, Special Projects for the Severely Disabled may only receive approximately $9.8 million in FY 1983. If this is the case, the President's request would provide sufficient resources to fund continuation projects in the second and third years, and about $1.3 million for new FY 84 projects. This would be more than $3 million less than is available for new projects in FY 83. (Only one new project was funded in FY 82. However, if Special Projects for the Severely Disabled does receive its full $11.259 million in FY 83, then the President's request would represent nearly a $1 million reduction in this important program.)

COALITION RECOMMENDATION: Funding at the level of $12.21 million for FY 84 is recommended in order to provide for adequate resources for new FY 84 projects.

JUSTIFICATION: The area of improving the capability of the rehabilitation system to successfully serve the needs of severely disabled persons depends substantially on this program. The need for this improvement is broadly accepted, and the potentials for individuals and the federal budget on a cost-benefit basis are very significant.

TECHNICAL ASSISTANCE

APPROPRIATIONS FY 81	 FY 82	 FY 83	FY 1984 AUTHORIZATION	PRESIDENT'S FY 84 REQUEST	COALITION RECOMMENDATION
.23	.25	0	pending	0	.25

(in millions)

PROGRAM DESCRIPTION: Section 12 of the Rehabilitation Act states that the Commissioner of RSA may provide " . . . consultative services and Technical Assistance to public or non-profit, private agencies and organizations." This authority was traditionally used to provide technical assistance to rehabilitation facilities in areas such as contract procurement, high technology, cost accounting, marketing, etc., to help facilities improve their performance in providing services to disabled persons. The Technical Assistance provided under Section 12 allowed facilities to be operated in a more business-like manner, become more self-sufficient and less dependent.

In the past, Technical Assistance had been funded at $250,000 per year. Although a small amount when compared to other programs, the appropriation was spread among many facilities since most Technical Assistance provided was of short duration and the amount of money needed for each consultation was relatively small.

The addition of Section 506 of the Act in 1978 caused confusion in the Technical Assistance program since it provided for Technical Assistance to "persons operating rehabilitation facilities" but only for the purpose of removing architectural barriers. Funding was shifted from Section 12 to Section 506 without the realization that this would not allow funding traditional Technical Assistance to rehabilitation facilities.

RECOMMENDATION: $250,000 should be appropriated in FY 1984 for Technical Assistance to rehabilitation facilities under Section 12.

JUSTIFICATION: Rehabilitation facilities need access to experts to advise them on issues relevant to providing employment and rehabilitation services to disabled persons. The low cost per consultation and the improvement in services resulting from the consultations make the small appropriations most worthwhile.

PROJECTS WITH INDUSTRY

APPROPORIATIONS FY 81	FY 82	FY 83	FY 1984 AUTHORIZATION	PRESIDENT'S FY84 REQUEST	COALITION RECOMMENDATION
5.25	7.51	13.0	pending	11.0	13.0

(in millions)

PROGRAM DESCRIPTION: The Projects With Industry (PWI) program authorizes contracts or jointly-financed cooperative agreements with employers and organizations for projects designed to prepare disabled individuals for gainful employment. Such projects provide training, employment and other services in work settings. Under PWI, the Rehabilitation Services Administration engages business, industry, labor unions and nonprofit organizations in employment of the handicapped. PWI increases the chances for successful placement because the client is exposed to and placed in a real work environment. The process of permanent placement is simplified because the employer already knows the client and only a payroll transfer may be required to hire a PWI graduate. Business and industry are more involved with the client; attitudinal barriers are reduced. PWI provides the client with financial incentives almost immediately and requires less time than the traditional rehabilitation process. At the same time, PWI is part of an overall rehabilitation program, but with more emphasis on the end results. In FY 1982, 72 PWI projecs were funded at $7.51 million. Over 9,000 placements, averaging $946 per placement, made this a successful job-training program. Placement retention rates were over 75%. The average annual wage for PWI graduates was $9,000; total income for persons placed by the program was $78 million. Taxes paid by PWI graduates alone offset the cost of the program.

IMPACT OF THE PRESIDENT'S 1984 BUDGET REQUEST: With the addition of $5 million in funding for FY 1983 under the emergency Jobs Bill, PWI will receive a total of $13 million in FY 1983. The President's budget proposal would be $2 million less than that. An additional 1500 handicapped persons could be placed into competitive jobs.

RECOMMENDATION: PWI should be funded at the FY 83 appropriation level of $13 million.

JUSTIFICATION: The success of the PWI program and its positive cost benefit ratio justify a substantial increase in funding. Documented savings in public assistance and taxes paid by the program would clearly exceed the appropriation for the program.

EVALUATION--SECTION 14

APPROPRIATIONS			FY 1984	PRESIDENT'S	COALITION
FY 81	FY 82	FY 83	AUTHORIZATION	FY 84 REQUEST	RECOMMEND.
1.820	0	0	pending	0	2.0

(in millions)

PROGRAM DESCRIPTION: Section 14 of the Rehabilitation Act calls for the Secretary to "evaluate the impact of all programs authorized by the Act, their general effectiveness in relation to their cost, their impact on related programs, and their structure and mechanisms for delivery of services...". This section of the Act has not been funded since FY 1981, at which time it received $1.820 million. The evaluation section funded projects which reviewed such aspects of the legislation as training, placement, Projects with Industry, the Client Assistance Program, and other programs authorized by the Act. Along with the review of these programs, important statistics were collected which gave an accurate profile of the clients being served and also indicated the cost-effectiveness of the programs.

RECOMMENDATION: The Rehabilitaiton Coalition recommends that Section 14 receive $2 million in appropriations for FY 1984.

JUSTIFICATION: Programs authorized by the Rehabilitation Act have proven cost-effective throughout their history. However, the Rehabilitation Coalition firmly believes that the evaluation data is *critical* to assuring the continued success of these programs. We are very disturbed that RSA has diminished efforts to collect client data and other evaluation statistics in recent years. Without such evaluation data, it may be difficult to accurately assess the quality of services rendered to disabled persons.

AMERICAN INDIAN VOCATIONAL REHABILITATION SERVICES PROJECTS

APPROPRIATIONS FY 81	 FY 82	 FY 83	FY 1984 AUTHORIZATIONS	PRESIDENT'S FY 84 REQUEST	COALITION RECOMMENDATION
.650	.624	.650	Pending	.650	.650

(in millions)

PROGRAM DESCRIPTION: Section 130 of the Rehabilitation Act of 1973, as amended, authorizes the provision of funds to the governing bodies of Indian tribes located on State and Federal lands, to provide vocational rehabilitation services for handicapped American Indians residing on such reservations.

JUSTIFICATION: The environment of the Indian reservation offers a severely limited range of employment opportunities for disabled American Indians. Thus, the rehabilitation services provided through Section 130 are different from those in the Basic State Vocational Rehabilitation Program.

In FY 1983, it is estimated that 575 persons with disabilities will be served by this program. This represents a slight decrease in the number of persons served in FY 1982. The Rehabilitation Coalition recognizes the unique need for the provision of services under Section 130, and recommends $650,000 for FY 1983.

SPECIAL RECREATION PROGRAMS

APPROPRIATIONS			FY 1984	PRESIDENT'S	COALITION
FY 81	FY 82	FY 83	AUTHORIZATIONS	FY84 REQUEST	RECOMMENDATION
2.0	1.884	*	pending	0	2.0

(IN MILLIONS)

PROGRAM DESCRIPTION: The 1978 amendments to the Rehabilitation Act of 1973 authorize a program for initiating special recreation projects for individuals with disabilities. Under Title III, Section 316 of the Act, grants are made to states and other public and non-profit agencies to pay part or all of the cost of establishing recreation program to aid in the mobility and socialization of persons with disabilities. The role of recreation in rehabilitation is an important one. Recreation and rehabilitation professionals maintain that there is a therapeutic value to participation in recreation programs and that recreational activities are an essential element of a balanced lifestyle. Programs established under Section 316 encompass a broad range of activities, including sports, music, dance, arts and crafts, camping, scouting and 4-H activities. Provision under the Act specify that existing resources be used whenever possible, thereby discouraging the development of new facilities and encouraging the integration of persons with disabilities into established community recreation programs. Congress indicated that funds appropriated under Section 316 should initiate programs and activities which could eventually be assumed by local public and private agencies. The program has proven successful in this regard, as most programs initially funded under Section 316 have received continued community support.

IMPACT OF PRESIDENT'S 1984 BUDGET REQUEST: the Administration has proposed that the Section 316 special recreation programs receive no funding in fiscal year 1984. The effect of this proposal includes:

o The elimination of a successful program to initiate cost-effective recreation projects and activities serving persons with disabilities. It should be noted that the twenty-three programs funded under Section 316 in 1982 served approximately 18,330 individuals.

o The loss of federal support for recreation as a valuable means of improving the health, social integration, and personal growth of persons with disabilities.

RECOMMENDATION: The Rehabilitation Coalition recommends an

ARCHITECTURAL AND TRANSPORTATION BARRIERS COMPLIANCE BOARD

APPROPRIATIONS FY 81	FY 82	FY 83	FY 1984 AUTHORIZATION	PRESIDENT'S FY84 REQUEST	COALITION RECOMMEND.
2.3	1.9	2.02	pending	1.7	2.02

(in millions)

PROGRAM DESCRIPTION: The Architectural and Transportation Barriers Compliance Board (ATBCB) is the only federal agency focusing exclusively on the accessibility needs of persons with disabilities. The Board provides federal agencies with minimum guidelines and requirements for federal accessibility standards issued under the "Architectural Barriers Act of 1968." The ATBCB also investigates alternative approaches to architectural, transportation, communications and attitudinal barriers confronting individuals with disabilities. Funds are used to sponsor research in a broad range of accessibility-related fields, including new technologies of informational cuing to assist with the identification of rooms and spaces, the evaluation of ground and floor surface treatments and the analysis of design considerations affecting people with multiple disabilities. Lastly, the Board is responsible for assessing the measures taken by federal, state and local governments and other agencies to eliminate barriers. The ATBCB provides technical assistance to these agencies and makes recommendations to Congress and the Administration regarding barrier removal.

IMPACT OF THE PRESIDENT'S 1984 BUDGET REQUEST: The Administration's budget request of $1.7 million for Fiscal Year 1984 represents a reduction of 15.8 percent. A funding decrease of this size would effectively eliminate the discretionary monies used for Board activities. The effects of the President's budget proposals include:

o The loss of funding available to sponsor research.

o The termination of technical assistance programs designed to aid states and local governments in meeting federal accessibility standards and developing state codes regarding accessibility.

o The potential inability of the ATBCB to meeting its Congressionally-mandated function regarding federal accessibility guidelines and requirements as a result of the proposed funding reduction.

RECOMMENDATION: The Rehabilitation Coalition recommends that the ATBCB be funded at $2.02 million in FY 1984.

appropriation of $2.0 million for the Special Recreation Programs.

JUSTIFICATION: In passing this provision, Congress recognized that the lack of adequate recreation programming for disabled individuals is one of the most glaring gaps in our existing social service funding. Continued support for Section 316 programs is the quickest and most cost-effective way to make recreational opportunities accessible to persons with disabilities.

*As this document goes to press, the RSA does not intend to allocate any of the FY 1983 Service Projects appropriations for Special Recreations Programs. Many observers contend, however, that the Congress intended to appropriate $1.884 million for these programs.

JUSTIFICATION: The ATBCB has a unique role in setting federal standards for accessibility. In addition, the research and technical assistance programs conducted by the Board represent critical components of efforts to eliminate the barriers confronting individuals with disabilities.

REHABILITATION COALITION'S FY 84 APPROPRIATION RECOMMENDATIONS FOR PROGRAMS AUTHORIZED UNDER THE REHABILITATION ACT OF 1973, AS AMENDED

($ in millions)

Program	Appropriations FY 1981	FY 1982	FY 1983	FY 1984 Authorization	President's 1984 Request	Rehabiliation Coalition Recommendation
Basic State Grants	854.259	863.04	943.9	Pending	943.9	1,037.8
Training	21.60	19.2	19.2	Pending	19.2	25.5
Independent Living	18.0	17.28	17.28	Pending	17.28	45.0
National Institute of Handicapped Research	29.75	28.56	30.06	Pending	30.06	37.5
Discretionary Service Projects:						
. Client Assistance	3.8	3.0	1.734	Pending	-0-	3.0
. Special Projects for the Severely Disabled	9.765	8.855	11.259	Pending	10.295	12.21
. Migrant Workers	1.325	.942	.951	Pending	.741	.942
. Helen Keller Center	3.2	3.137	3.5	Pending	3.5	3.5
. Comprehensive Rehabilitation Centers	1.02	-0-	-0-	Pending	-0-	2.0
. Technical Assistance	.25	.25	-0-	Pending	-0-	.25
. Projects with Industry	5.25	7.51	13.0	Pending	10.908	13.0
. Evaluation	1.02	-0-	-0-	Pending	-0-	2.0
. Service Grants to Indian Tribes	.65	.624	.65	Pending	.65	.65

(CON.'T)

Program	Appropriations FY 1981	FY 1982	FY 1983	FY 1984 Authorization	President's 1984 Request	Rehabilitation Coalition Recommendation
Discretionary Service Projects (con.'t):						
. Special Recreation	2.0	1.884	*	Pending	-0-	2.0
National Council on the Handicapped	.205	.197	.193	Pending	.193	.193
Architectural and Transportation Barriers Compliance Board	2.3	1.9	2.02	Pending	1.7	2.02

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* As this document goes to press, RSA does not intend to allocate any of the 1983 service project appropriations for Special Recreation Programs. Many observers contend, however, that the Congress intended to appropriate $1.884 million for these programs.

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Southern Illinois
University at Carbondale
Carbondale, Illinois 62901

Rehabilitation Institute
Division of the College of Human Resources
618-536-7704

June 30, 1983

Judy Wagner
House Sub Committee on Select Education
U. S. House of Representatives
Washington, D.C. 20515

Dear Ms. Wagner:

During a discussion at the National Rehabilitation Association (NRA) Second Legislative Seminar, March 22-25, 1983 in Washington, D.C., I raised some concerns about a proposal to use a weighted case outcome system for distributing case service funds to the states for their basic state grant Vocational Rehabilitation (VR) programs. My primary objections were that the proposed system was overly simplistic, i.e., it ignored both the experience of business and industry as to the pitfalls of Management by Objectives (MBO), and the deficiencies of the research base in related areas of rehabilitation. At that time, you and several others asked if I would share copies of this research information, to which I agreed. Unfortunately work and personal commitments precluded my delivering on that promise in a timely fashion and for that I sincerely apologize. I am, however, providing a summary of the requested information herewith.

In 1978, I reviewed the literature from both general management and rehabilitation on the use of objectives for improved management of the rehabilitation system. Enclosed is a copy of the published results of that study, the proper citation for which is:

> Lorenz, J.R. Setting performance objectives & evaluating individual performance in rehabilitation settings. *Journal of Rehabilitation Administration*, 1979, *3*, 5-12.

The reference list at the end of the article includes those studies and papers upon which my conclusions were based. I have underlined those sections from the article which document my concerns.

I will, however, attempt here, to summarize for your convenience, the essence of what we know and do not know both from business and industry, as well as rehabilitation about MBO type systems. This helped form the bases of my objections to the proposed systems. We know that the use of outcome measures for management purposes does have an effect on the entire production or service enterprise involved.

The implementation of such a system nationwide, without adequate research and demonstration, could, and likely would, cause undesirable side effects. One need only examine the undesirable impact of the use of the current "26 closure" system in Vocational Rehabilitation, or the "body count" in Viet Nam to see the potential abuse about which I am talking. Adequate research and demonstration could avoid such negative surprises.

We know that for any such system to work, it must have had major involvement at the developmental stages from those who will implement it. The system which was proposed had no such meaningful input. Moreover, the responsible use of such a system mandates the need for appropriate training for administrators and supervisors throughout the system prior to or at least concurrent with implementation. Nothing in the proposal even remotely addressed this issue.

Finally, the clearest findings from business and industry show that such systems must not only include the "what" objectives, but also the "how" objectives. The one thing we can conclude from the rehabilitation research literature is that we know very little about the "how" component. If our true concern in this proposed federal legislation is ensuring that handicapped people get appropriate and high quality service (remember most VR clients only get one opportunity with one counselor for these services), then it is essential that we emphasize a growth and development model with the states. To use a judgement and punishment model would only ensure that clients in states with poorer track records would get even less in the way of needed services and resources.

In short, the basic concept underlying this proposal, while having some merit, was naive when existing research results are considered. It is far too simplistic in its design since it ignores the research capability of the NIHR as well as the training capacity within RSA. I would be most pleased to address any further questions you might have, or to embellish any additional areas of the literature upon request. Let me also assure you that I am now able to provide a much more timely response. I hope that this is still of some help to you, thank you for your patience.

Yours sincerely,

Jerome R. Lorenz, Ph.D., CRC
Professor and Director

JRL/jlh

cc: Jack Duncan

SETTING PERFORMANCE OBJECTIVES AND EVALUATING INDIVIDUAL PERFORMANCE IN REHABILITATION SETTINGS

Jerome R. Lorenz
Southern Illinois University at Carbondale

This paper constitutes an attempt to bridge the gap between rehabilitation and management research by a review of the current literature from both fields as it relates to setting performance objectives and evaluating individual performance in rehabilitation settings. Questions relating to the reasons for setting performance objectives and evaluating individual performance, and to the type of objectives to set, are explored. The concepts of "what" and "how" objectives are investigated and a specific approach for setting objectives and evaluating individual performance in a rehabilitation setting is discussed.

Giblin and Ornati (1977) define the optimization of human resources as "the condition in which a set of interdependent, goal related relationships, each peculiar in its component parts to a specific organization, are simultaneously satisfied to the highest possible degree without unacceptably lessening the satisfaction of other significant goals" (p 5). To that end, they state, it is essential that tasks performed by employees be related to organizational goals. In contrast to the optimization of human resources, Harvey (1977) uses a humorous satire to tell us the many ways in which organizations reduce competent, dedicated employees to the status of *phrogs*. According to Harvey, *phrog* is spelled with a ph because all persons reduced to that lowly status "try to hide their phrogginess from themselves and others ..." (p. 17). Harvey (1977) contends that this dehumanizing process is done on purpose:

> All organizations have two essential purposes. One is to produce widgets, glops and fillips. The other is to turn people int phrogs. In many organizations, the latter purpose takes precedence over the former. For example, in many organizations, it is more important to follow the chain of command than to behave sensibly. (p. 17)

A second essential condition put forward by Giblin and Ornati (1977) is that the majority of work time must be devoted to tasks which relate to organizational goals. But Harvey (1977) maintains

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Special thanks are given to Irene B. Hawley, Ph.D., Assistant Professor, Rehabilitation Institute, Southern Illinois University at Carbondale for her critical comments and suggestions on the manuscript.

* * *

This paper is based upon a presentation made on April 26, 1978 at St. Petersburg Beach, Florida, for the Region IV Short Term Training Conference entitled "Human Resource Optimization in State Vocational Rehabilitation Agencies." The conference was conducted by the Emory University Rehabilitation Research and Training Center with funds from the Rehabilitation Services Administration (Grant #45-P-20613/4-01).

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that "most phrogs (organizational employees) spend more time flicking flies in the fog than in draining the swamp. As best as I can tell, their behavior is circular. If they spend time draining the swamp, there would be no flies to flick and no phrogs. For that reason, it is very important to maintain the swamp as it is rather than drain it" (p. 18).

Thirdly, Giblin and Ornati (1977) believe that the tasks a worker performs should reflect the highest ability level of that worker. Harvey (1977), on the other hand, suggests that ". . . the better a phrog can tolerate the loneliness of his lily pad, the more competent he becomes at speaking the Language of Ribbit, the more facile he becomes in flicking flies, the more skillful he becomes at appropriating others lily pads, and the more adroit he becomes at maintaining the swamp, the more likely he is to become fresident" (p. 18).

Finally, Giblin and Ornati (1977) take the position that structure and technology must be integrated to ensure improved task performance. Harvey (1977) however states that most organizations really engage in organizational development by deception (ODD) or cosmetic organizational development. He describes ODD as "any activity designed to facilitate phrog kissing, phrog chorus building, interlily-pad conflict resolution, phrog sensing, phrog style assessment, marsh groups, tadpole development and phrog coaching in the absence of swamp drainage and area reclamation are examples . . ." (p. 18). With regard to performance appraisal Harvey (1977) notes that phrogs "are ultimately evaluated for what they do in their own mud flats," not "for how well they sing in the chorus" (p. 17).

Is it all as bad as Harvey (1977) sees it, or as cut and dried and mechanistic as Giblin and Ornati (1977) suggest? The purpose of this article is to help answer this question by reviewing the literature dealing with bridging the gap between rehabilitation and general management research in an effort to identify ways of setting performance objectives and evaluating individual performance so as to optimize human resource utilization in rehabilitation.

Why Set Performance Objectives & Evaluate Individual Performance?

We in rehabilitation are living in an age of accountability. Given the nation's economic condition, it is highly unlikely that large amounts of new resources will be allocated to the rehabilitation system. In fact, it is far more likely that there will be increasing pressure for greater and greater output in the face of decreasing or, at least, nonexpanding resources. Programs that are not highly productiv will be eliminated or reorganized. Such pressures ar somewhat new to the field of rehabilitation; unti recently it had been assumed that "doing goo things for handicapped people" was the "Lord' work" and thus was to be supported without question. One need only to look at the strong bipartisa support of rehabilitation legislation prior to 1973 However, as Rule and Wright (1974) point out, th 1973 Rehabilitation Act was the first such legislatio in history to be vetoed, not just once but twice i two years, on grounds of being inflationary an relatively ineffective, i.e., providing services whic resulted in jobs that paid poverty wages to a relatively small number of the least disabled persons Rule and Wright (1974) strongly suggest that what i needed is better accountability, including the settin and attainment of clear goals reflecting the basi purpose of rehabilitation programs in this country and that performance in relation to those goals mu be tied to the intrinsic and extrinsic reward system of the agency.

Unfortunately, according to Coven (1977), th fact that accountability goals and methods ar viewed by staff as imposed from the top in a non democratic fashion while failing to meet eithe counselor or client needs frequently results in resi tance and conflict. Since they almost always enta the appraisal of individuals, the concepts an processes of accountability produce a great deal anxiety among those likely to be evaluated.

Now the supervisors' and managers' dilemma b comes clear. If we are to survive in today's politic arena, it is absolutely essential for management set clear and relevant performance objectives and evaluate individual performance against those obje tives. On the other hand such procedures produ anxiety, resistance, and conflict among employee Managers and supervisors have traditionally ha three primary roles: (a) to achieve organization goals, (b) to judge (evaluate) individual performan and make decisions about salary and promotio and (c) to help develop effective and promotab employees (Beer and Ruh, 1976). Effective perfor ance in that third role is best accomplished by fir line supervision which emphasizes guidance ar feedback. Beer and Ruh (1976) go on to point o that even in business and industry these roles oft become confused and conflicting. In most organiz tions, it is that third role, employee developme that is most difficult.

Unlike business and industry, rehabilitation in th country has devoted very few resources to increasi

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the effectiveness of supervisory personnel (Aiken, Smits, and Lollar, 1972). Exclusive emphasis on production and on obtaining organizational objectives only results in initiation of structure at the expense of staff development and satisfaction. We need (a) more research into the staff development component of the rehabilitation supervisor's job and (b) better training of supervisors for that job (Aiken et al., 1972). Beer and Ruh (1976) cite research in business and industry to show that the supervisor's role as a judge interferes with his/her role as staff developer. They go on to suggest the Performance Management System (PMS) as a potential solution (to be explored more fully below). Giblin and Ornati (1977) point to the underutilization of large numbers of employees, resulting in high turnover and less than optimal mission accomplishment. They suggest that a goal-orientated management process would help to alleviate this situation by improving leadership practice, communication, and morale, and by a generally more efficient utilization of human resources.

Performance appraisal in terms of the established goals is essential if there is to be accountability in the system. Burke and Wilcox (1963) recognize performance appraisal as a widely practiced management activity used to provide (a) a rational basis for promotions and salary increases, (b) a framework for long-range personnel planning, and (c) a device for training and coaching. It is in this third area that most problems seem to develop, and where the least research is available. As a result, the developmental aspects of many performance appraisal systems are at best hard to find and all too often nonexistent.

What Types of Objectives Should Be Set?

Performance objectives can be classified into two types: those related to the "what" of performance (or outcome) and those related to the "how" of performance (or process). Outcome objectives, which specify the status of the client following provision of service, should reflect the benefits the client has received as a result of the program. Process objectives, which relate to specific tasks performed by staff during the rehabilitation process, are formulated on the basis that, if these tasks are performed properly, the probability of a successful client outcome is enhanced (Commission on Accreditation of Rehabilitation Facilities [CARF], 1977).

In recent years, Management By Objectives (MBO) has enjoyed increasing popularity. This approach focuses on the results or the "what" of production rather than on the means or "how" of production. The reason for its popularity is, according to Beer and Ruh (1976), that it produces results while avoiding any discussion of how the goals are accomplished. In effect, it allows the supervisor to avoid dealing with "emotionally laden interpersonal situations" (p. 59). The question becomes quite simply, "did you or didn't you accomplish the goal?" Of course, if employees are to improve they need to understand what behaviors must be modified or adopted for best results. Moreover, if management is to help employees to develop, it must be able to identify the behaviors that lead to the desired performance; this, however, is not always the case (Beer and Ruh, 1976). In addition, failure to attend to the "how" of accomplishment can result in short-term gains but long-term damage to the organization. An example might be a regional supervisor who, in an effort to increase closures for an extended time period, provides services only to the least severely handicapped; as a result, a number of the resources serving the severely handicapped go out of business and thus are no longer available to the region.

In a study by Downes, McFarland, and Alston (1974), there was considerably more agreement among rehabilitation counselors on the use of process objectives for performance appraisal than there was on outcome objectives, in particular "Status 26" criteria. While the methodology of that study was weak and not entirely consistent with other literature, it is still interesting to note that process or "how" objectives seemed to be more agreeable and less anxiety-producing to rehabilitation counselors than outcome objectives.

Levinson (1976) summarizes the thinking in this area quite well. While outcomes are important and most performance appraisal systems focus only on results, there may be some truth to the old adage, "It's not the winning or losing that counts, but how you play the game" (p. 50). It would seem then that both types of objectives should be set and appraised. The remainder of this section will deal with the "what" and "how" objectives related to rehabilitation.

The "what or outcome objectives. The type of outcome measure used impacts on the entire system, including the management information system (MIS); the agency organizational structure; clients' hopes and expectations; performance evaluation of counselors, including advancement and motivation; the program evaluation system; and the training of new counselors (Backer, 1977); in effect, it literally defines the results of rehabilitation services. In recognition of this impact, and in the face of strong demands for accountability, both the Department of

Health, Education, and Welfare's Rehabilitation Services Administration (DHEW/RSA) and the Commission on Accreditation of Rehabilitation Facilities (CARF) have required the institution of Program Evaluation (PE) systems and set standards for these systems in the various state vocational rehabilitation (VR) agencies and accredited rehabilitation facilities. At a minimum both agencies require that the PE system provide the information needed to judge the worth of a program and to make necessary program improvements. The most frequently used and long revered outcome measure/objective, the "Status 26" closure, clearly falls short of both sets of standards for PE systems (Backer, 1977). Since the "Status 26" closure has been so popular as an outcome measure/objective it would seem worthwhile to examine it in some depth.

Why has the "Status 26" closure been used so consistently and for such a long time, even in the face of severe criticism? In large part this is due to the extraordinary success of this measure/objective in the political, legislative, and funding arenas. It is a very concrete criterion, easily transformed into financial values, and hence more appealing than abstract quality-of-life measures to those persons who have to make tough financial decisions with limited resources. The fact that it has long been a part of the VR agency's MIS systems and of the R-300 report allows for year by year comparability virtually all the way back to the beginning of the civilian rehabilitation system in this country. Any change, no matter how good, would not only jeopardize this advantage but would also violate some 50 years of inertia. Lastly, while many of the shortcomings of the "Status 26" criterion have been recognized for a long time, they are not overly visible and hence have been relatively easy to ignore (Backer, 1977).

What are some of the problems of using the "Status 26" closure as the principal outcome measure/objective? The basic difficulty is that it combines and confounds a number of distinctly different outcomes and treats them as if they were equivalent indices of success. Some of these outcomes include categories such as: practice of a profession, other full-time competitive employment, less than full-time competitive employment, self-employment, homemaking, farm or family work (including payment in kind), sheltered employment, home industries, and other gainful homebound work (Backer, 1977; Bule and Wright, 1974; Worrall, 1978). The lack of an accurate indicator strains both the internal and external evaluation of the system by making it difficult, if not impossible, to evaluate both the effectiveness of counselor performance and the cost-benefit ratio on tax dollars spent (Worrall, 1978). Any system which gives equal credit for each "26" closure regardless of inputs, throughputs, and outputs may motivate counselors to behave in ways that are not in the best interests of the client, such as creaming (Hawryluk, 1972; Bule and Wright, 1974).

Other criticisms of the "Status 26" closure include the following: It treats temporary data as if they were permanent, is a very crude indicator, fails to recognize quality of placement, fails to recognize client gain, may militate against good rehabilitation practice, fails to recognize why client sought services in the first place, ignores differences in caseload and geographic difficulties, misses "Status 28" made significant gains, militates against the severely handicapped, is not helpful in improving counselor performance, completely ignores nonvocational factors, and treats clients' achievement as if it were the agency's (Backer, 1977; Coven, 1977; Hawryluck, 1972; Thomas, Henke and Pool, 1976). Vash, quoted in Backer (1977), refers to an article which

> likened what happens when the State-Federal VR program counts numbers of 26 closures with what happened in My Lai when 'body count' became the measure of whether we were winning the war. The message was, "Get bodies, you have to get bodies!" In My Lai, that meant civilians, including children. In VR, it may mean the dubiously or very mildly disabled. (p. 19)

Not only is the "Status 26" measure/objective conceptually weak but since it is used for performance evaluation and hence, for the distribution of rewards, it can and does exert a potent influence on behavior. To the extent that the mere accumulation of "Status 26" closures does not reflect the overall purpose of the rehabilitation program in this country, its establishment as the sole outcome objective is counterproductive. Counselors are openly challenging it as a measure/objective, characterizing it as dishonest and incomplete. Thomas et al. (1976) suggest that the "Status 26" closure experience has caused many a rehabilitation counselor to learn to work around it, leave, or learn to play the game. It deprofessionalizes counselor and supervisor alike.

Outcome measures/objectives which, according to the First Institute on Rehabilitation Issues (Backer, 1977), should replace the simple "Status 26" closure include vocational functioning and potential, economic independence, physical functioning, and psychosocial functioning. Other authors have called for increased emphasis on the severely disabled and on the provisions of the 1973 Rehabilitation Act, for consideration of the nature and quality of service.

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removal of the problem of secondary gains, some consideration of occupational mobility, and, at a minimum, for multiple measurements (Backer, 1977; CARF, 1977; Hawryluk, 1972; Thomas et al., 1976).

Backer (1977) has provided a very extensive review of client variables that should/could be addressed by new outcome measures and of measures potentially available as alternative outcome objectives. In the following, three general classes of outcome objectives/measures will be discussed briefly, viz., actuarial/weighted closure or caseload profiles, scales, and benefit cost approaches.

Probably the most promising alternative approach to the "Status 26" approach is a weighted case closure system that takes into account the fact that some clients are more difficult to place than others, recognizes client gain, and seems to provide a far better measure for service criteria, counselor performance, and cost benefit. Most weighted systems, while somewhat problematic, have proven preferable to the current "Status 26" closure measure (Backer, 1977; Worrall, 1978). Having reviewed a substantial number of these weighting schemes, Worrall (1978) concludes that they are only as good as the data upon which they are based. He further points out that these systems can be constructed to include incentives for working with and for the severely handicapped, and that such measures can be used to evaluate and compare the work of individual counselors. Walls and Moriarity (1977) suggest a slight modification of the weighted case closure approach, namely, the caseload profile which not only avoids the problem of mixing nonadditive and nonlinear types of data but gives the counselor substantially better and more complete information upon which to base needed improvements.

The use of scales has been proposed to measure client gains other than narrowly vocational outcomes. Westerhide and Lenhart (cited in Worrall, 1977), after fully reviewing these approaches, conclude that they all fail to fully objectify what they are measuring; moreover their abstractness greatly restricts their utility for policy formulation. One scale that in the opinion of this author seems to have particular merit in terms of its theoretical and statistical rigor is the Human Service Scale (Reagles and Butler, 1976).

Benefit cost, while conceptually sound, presents massive measurement difficulties and requires complex and somewhat problematic mathematical models and assumptions (Worrall, 1978).

The "how" or process objectives. Beer and Ruh (1976) have studied the Corning Glass experience with MBO and concluded that "how" or process objectives and assessments should be used in conjunction with MBO so as to optimize employee development and human resource utilization. It should be made clear that this is in no way an attempt to recreate the trait-factor approach to employee appraisal used in the 1950s in this country. The traits underlying that approach were vague and subjective at best; and a high rating on most jobs tended to require god-like qualities on the part of the employee. Proven largely ineffective, such a system is not advocated here. What is proposed instead is the in-depth study of the *modus operandi* of successful workers as a basis for extensive training, goal setting, appraisal, and feedback to employees in a system that would parallel MBO. In essence, such a system would provide employees with specific behavioral information on how to do the job better (Beer and Ruh, 1976).

One approach that was fairly popular in the management literature during the early 1970s was the Behaviorally Anchored Rating Scale (BARS) which attempted to capture employee performance in multi-dimensional behaviorally specific terms. It utilized a critical incident technique to create performance dimensions that were subsequently retranslated and scaled. Billed as vastly superior to the vague trait approach, this technique purported to enhance its reliability and validity by casting the supervisor in the role of observer rather than that of judge. Research on the use of this tool with a number of different occupations has led to the following conclusions. Leniency effects are inconclusive. Dimension independence is largely undemonstrated and reveals significant halo effects. Reliability is moderate and is only slightly higher than alternate techniques. There is currently little reason to believe that BARS is superior to other employee evaluation instruments. However, we are cautioned not to throw the baby out with the bath. An assessment procedure for the "how" objective attainment is clearly needed, and some form of behavioral approach seems to hold the most promise (Schwab, Hineman, and DeCoths, 1975).

Beer and Ruh (1976) describe the development and use of the Performance Description Questionnaire for the "how" portion of the employee appraisal at Corning Glass. While they report general satisfaction with this instrument and approach, no information is given on the performance of the instrument with respect to the indicators cited by Schwab et al. (1975).

Some attempts have been made to apply similar approaches specifically to rehabilitation (Bolton, 1978; Fraser and Wright, 1975; Greenwood and Cooper, 1976). Bolton's (1978) assessment of the state of the art in this area has led him to conclude that our knowledge of counselor behaviors that produce successful rehabilitation outcomes is virtually nonexistent. While recognizing that assessment of how the counselor achieves results is essential, he strongly suggests that it should only be used for diagnostic purposes at this time.

How Do You Set Performance Objectives?

Counselors are frequently required to submit to changes in reporting requirements and in the manner in which their performance is appraised, with little or no opportunity for input. If counselors thought that such changes would enhance the measurement of their performance and provide significant feedback so as to help them do a better job, they would probably respond more positively. For the most part, they tend to view such changes as simply more paperwork and thus something to be resisted (Backer, 1977).

Staff should be totally involved in creating both the "what" and "how" objectives against which they will be assessed. Such involvement provides for significant input, subsequent ownership, and thus acceptance of and commitment to such a system (CARF, 1977). Involvement is required both during the group planning phase for the system overall and during the individual negotiation phase which should result in a job contract for a defined period. Such an approach requires that the employee have the skills to effectively engage in the negotiation. Both the supervisor and the employee must agree not only on the outcome objectives but on the prerequisite specific behaviors/tasks (Burke & Wilcox, 1963; Turner and Lee, 1976a).

A specific example of the use of such an approach in rehabilitation is the Objectives Priorities System (OPS) as described by Kay (1978). A modification of the CARF (1977) system for individual counselors, OPS is, in essence, a refined MBO system which prioritizes objectives and provides a composite index score. Negotiation is essential if motivation is to occur. It requires that there be a clear logical relationship between clients and services, and between purposes and measurable objectives. Otherwise the resulting contract will be purely arbitrary and will not produce the desired effect.

How Do You Evaluate Performance and What Do You Do With The Results?

As has been mentioned earlier, after using the MBO system for several years the Corning Glass Company found that it had several positive features as well as some distinct disadvantages. The Performance Management System (PMS) was developed in an effort to capitalize on the positive aspects. Since the field of rehabilitation has only recently become concerned with MBO and the issue of accountability, we may be able to avoid the pitfalls of our counterparts in business and industry by learning from their experience. Rather than focusing solely on the "what" of performance we should include the "how." Figure 1 shows how this might be accomplished by means of the PMS model. Essentially PMS has three parts, viz., MBO, Performance Development and Review (PDR), and Performance Results Evaluation (PRE). What makes the PMS approach so unique is its conceptualization in terms of these three distinct and temporally separate, yet interactive aspects (Beer and Ruh, 1976). An absolutely essential ingredient of this system is the performance improvement plan that is included under the PDR (Schlesinger, 1976).

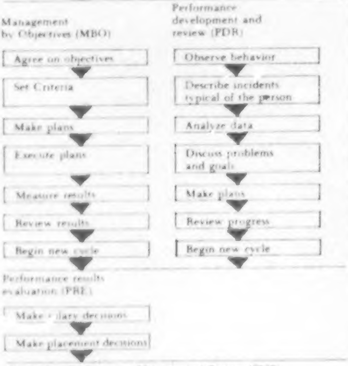

Figure 1. Performance Management System (PMS) (Beer and Ruh, 1976)

It is suggested that Kay's (1978) OPS system take the place of the MBO portion of the PMS in rehabilitation settings. The PDR portion, however, presents a problem. Bolton's (1978) findings suggest that we

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know far too little about this area to be able to conduct an effective performance development review. This certainly underscores our urgent need for research in this area. Such research should include at lease an attempt to use the Performance Description Questionnaire approach. In the interim we should use what we know strictly for diagnostic purposes, i.e., for the purpose of assisting employees who are having trouble, while minimizing the impact of the PDR portion of the model on the PRE.

While we are somewhat deficient in terms of the content of the PDR portion of PMS, we certainly have good information relative to how it should be approached with the employee. Burke and Wilcox (1963) have outlined four conditions necessary for successful performance appraisal: a) High levels of subordinate participation are essential in the developmental interview, b) the supervisor must be perceived by the employee to be helpful rather than critical, c) the supervisor must be willing to provide solutions to job problems that are hampering the subordinate, d) both must jointly set specific goals for the subordinate for the immediate future. This approach is, of course, not limited to the developmental interview but reflects a general supervisory style. There is good research evidence to show that these skills can be learned; it would seem most important that rehabilitation supervisors be given training in them.

With regard to the PRE portion of the model, Turner and Lee (1976b) provide and excellent approach to connecting the MBO/OPS and PDR with the PRE. They propose a system of performance contracting as the sole or at least primary basis for pay increases and promotion. They further note that, to be successful, such a system must allocate sufficient funds to pay maximum merit increases to all employees who successfully complete their contract. In addition, a true cost-of-living adjustment must be built in if a real reward is to be given.

Coven (1977) suggests that accountability data should not be used for judging and blaming the employee but rather for promoting growth and development. The PMS system put forward by Beer and Ruh (1978) allows the supervisor to both judge and develop employees. Backer (1977), CARF (1977), and Turner and Lee (1976a) support the idea of attempting both with employees.

Thus it may not be absolutely necessary for all of us to turn into phrogs (Harvey, 1977) in order that the organizations for which we work be accountable. It just requires that supervisors be properly trained in goal setting and performance appraisal. Goal setting should include not only "what" objectives but "how" objectives and be discussed by the supervisor in a supportive developmental fashion. There should be a clear link between the employee's performance (both "what" and "how") and discussion regarding pay and promotion. Moreover, supervisors must establish goals in a like fashion with their supervisors in order to encourage them in turn to engage in employee development behavior.

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COMMENTS ON THE LORENZ THEORY ARTICLE

By *Anthony S. DeSimone*, RSA Regional Program Director, Region X, Seattle, Washington.

I have reviewed "Setting Performance Objectives and Evaluating Individual Performance in Rehabilitation Settings," hoping for a reasonably clear review of the issues and potential solutions in this most critical area. After reading the article, I became more impressed with the author's inexhaustible use of acronyms and references than the subject with which he was addressing. Admittedly Dr. Jerome Lorenz has chosen a most difficult subject to write about. In my opinion it strikes at the very heart and soul of the rehabilitation process. As an Administrator for the Federal program for the past 30 years, I have heard discussions of this nature many times.

To his credit Dr. Lorenz has attempted the almost impossible task of weaving together the findings of over 30 authors. While his intentions are of the highest order, it becomes somewhat difficult to follow the logic of the article. What is clear and Dr. Lorenz deserves to be commended for it, is the need to bring these issues out in the open to be carefully assessed in the hard reality of practice. What is clear is that public agencies have an awesome responsibility for developing a system of rewards or incentives that goes beyond the status 26 closures. What is clear is that VR counselors in the public program are unique in the human services delivery system and must be held accountable for the authorization and expenditure of public funds. What is clear is that the services purchased must be quality services and that handicapped persons get the best possible service available.

In my opinion, management by objectives is the key to the rehabilitation system both in terms of case management and in terms of performance management. In New Jersey, the general agency sets an overall state goals after management has agreed with counselors on their own individual expectations of achievements. Counselors, through a representative committee, express their concerns directly to top level management and join in the development of policies and procedures affecting case flow and process. The net result is better services to handicapped people.

Surely the VR system is a dynamic concept and despite its critics it will survive as long as we can make healthy constructive recommendations for improving accountability.

* * *

By *Mary E. Worrall*, Training Officer, Vocational Rehabilitation Division, Minnesota Department of Economic Security, St. Paul.

Evaluative, judgmental performance appraisals do not provide for counselor/subordinate participation and mutual goal setting and will not further employee development. The single performance criterion, status 26 closure, currently used in vocational rehabilitation encourages judgmental performance reviews by supervisors because performance is evaluated only by outcome. Dr. Lorenz's review of the relevant literature indicates that the individual performance appraisal process and subsequent individual performance can be improved by using more sophisticated techniques combining both outcome and process criteria.

Administrators and practitioners have long recognized the problems inherent in the status 26 outcome criterion. It has led to distortion of the program's intent, role conflicts for counselors and supervisors and has resulted in limiting services to clients by encouraging counselors to screen out the more difficult clients and to terminate services too early in order to obtain the yearly quota of "26's". The "26" outcome criterion fails to recognize extra effort expended in serving difficult populations, inadequately evaluates the quality of services provided to clients who are closed unsuccessfully after a

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plan was initiated and it does not encourage the development of information which may be useful in more effectively delivering services to target disability populations. Human resources will be underutilized and the provision of quality client services will be delayed until process performance objectives are set. Counselors will be enabled to develop individual learning contracts more efficiently when they incorporate feedback regarding both process and outcome objectives.

A weighted closure system, the Caseload Profile and the Human Services Scale, although needing further refinement, offers alternatives for measuring outcome objectives. Process objectives might be more adequately established and assessed through the Behaviorally Anchored Rating Scale of the Performance Questionnaire.

Dr. Lorenz established the importance of the process used by supervisors in both setting and evaluating performance. He identified the Objective Priorities System as a tool to be used in negotiating *outcome* and *process* goals. A portion of the Performance Management System could be useful to supervisors for evaluating *process* and *outcome* performance and in developing a performance improvement plan.

The implications for staff development are clear. Supervisory skills in conducting effective performance appraisals can be sharpened through training in the conditions and elements necessary for successful performance appraisals. Supervisors can be trained to use the Performance Management System which might serve as a desirable method to use to set objectives and evaluate individual performance. A system of individual development planning has two significant benefits. It is more likely to improve individual performance because the needs of each employee are identified and learning contracts negotiated. The performance gaps of the agency's total program can be analyzed and plans for improvement can be developed systematically.

Excerpts from "*Up the Organization: How to Stop the Corporation from Stifling People and Strangling Profits*" by Robert Townsend (Greenwich, Connecticut, Fawcett, 1970).

EXCUSES

When you get right down to it, one of the most important tasks of a manager is to eliminate his people's excuses for failure. But if you're a paper manager, hiding in your office, they may not tell you about the problems only you can solve. So get out and ask them if there's anything you can do to help. Pretty soon they're standing right out there in the open with nobody but themselves to blame. Then they get to work, then they turn on to success, and then they have the strength of ten.

MISTAKES

Admit your own mistakes openly, maybe even joyfully.

Encourage your associates to do likewise by commiserating with them. Never castigate. Babies learn to walk by falling down. If you beat a baby every time he falls down, he'll never care much for walking. Beware the boss who walks on water and never makes a mistake. Save yourself a lot of grief and seek employment elsewhere.

HIRING

To keep an organization young and fit, don't hire anyone until everybody's so overworked they'll be glad to see the newcomer no matter where he sits.

TOO MUCH VS. TOO LITTLE

Too little is almost always better than too much.

Space: Too much brings out the worst in empire builders. They'll fill up the excess so fast you'll wind up with too little again. Too little makes you creative in your use of people. Too much puts the company emphasis on office grandeur, not on service and performance.

People: One person with only half a job can wander around and do real damage in his or her spare time. The best organizations are sufficiently understaffed so that if somebody does something that overlaps or invades your area of responsibility, your second reaction is: "Great! If you've got time to do that, you do it from now on." This feeling comes right after the first flash of territorial hostility. Organizations that have time to get into jurisdictional disputes are almost always overstaffed.

Money: A tight budget brings out the best creative instincts in man. Give him unlimited funds and he won't come up with the best way to a result. Man is a complicating animal. He only simplifies under pressure. Put him under some financial pressure. He'll scream in anguish. Then he'll come up with a plan which, to his own private amazement, is not only less expensive, but also faster and better than his original proposal, which you sent back.

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UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D.C. [illegible]

July 5, 1983

Centers for Independent Living
Supported in Whole or Part By Grants Under
Title VII, Part B, of the Rehabilitation Act of 1973

INDEPENDENT LIVING

OCCASIONAL IDENTICAL LETTER
TO
TITLE VII, PART B GRANTEES
&
GRANT ASSISTED CENTERS
FY 1983

Number Twenty-four

UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D.C. 20202

July 5, 1983

Dear Colleague:

Enclosed is an updated directory of Centers for Independent Living supported in whole or part by grants under Title VII, Part B, of the Rehabilitation Act of 1973.

Shown in the left column is the grantee; the right column shows the Center(s) supported by each grantee. There is at least one grant in each State including the District of Columbia, Puerto Rico, the Virgin Islands, and American Samoa, for a total of 74 grantees. Because a number of grantees have chosen to contract with more than one Center organization, a total of 150 Centers are receiving assistance. The ratio of Federal support to total support for each grantee and Center varies from only partial assistance to nearly full support.

Telephone numbers followed by TDD indicate that both voice and telecommunication devices for deaf and hard of hearing persons are accessed by the same number. Other Centers have separate lines for voice and TDD services. If only one number is listed, it is assumed that TDD service is not available.

We would appreciate being apprised of any corrections that you may note at this time or changes as they occur in the future. You may write to Independent Living Projects Branch, Department of Education, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration, 3214 MES Bldg., 400 Maryland Avenue, S.W., Washington, D.C. 20202.

Sincerely,

William J. Hean, Ph.D.
Chief, Independent Living
Projects Branch

Enclosure

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CENTERS FOR INDEPENDENT LIVING

Supported in Whole or Part by Grants Under

Title VII, Part B, Rehabilitation Act of 1973, as amended

STATE	GRANTEE	CENTER LOCATION
ALABAMA	J.W. Cowen Division of Rehabilitation and Crippled Children Service 2129 East South Blvd. P.O. Box 11586 Montgomery, AL 36111 (205) 281-8780	Patricia A. Sheets Independent Living Center 3421 Fifth Avenue, South Birmingham, AL 35222 (205) 251-2223
ALASKA	Thelma Hamson-Smith Division of Vocational Rehab. Department of Education Pouch F, M.S. 0581 Juneau, AK 99811 (907) 465- 2814	Audrey Aanes Access Alaska 841 Cowling Road Anchorage, AK 99503 (907) 563-4386
AMERICAN SAMOA	Timothy Halsom Office of Vocational Rehab. Manpower Resources American Samoa Government Pago Pago, AS 96799 (684) 633-1805	same
ARIZONA	Roger Hodges Rehabilitation Services Administration Department of Economic Security 1400 West Washington Phoenix, AZ 85007 (602) 255-3332	Rich Heiligen Arizona Congress for Action-ILC 1016 North 32nd Street Phoenix, AZ 85008 (602) 244-2708 Sylvia Ames Lamont Metropolitan IL Center 3333 E. Grant Road Tucson, AZ 85716 (602) 244-2706
ARKANSAS	Theodosia Cooper Division of Rehab. Services Department of Human Services 1401 Brookwood Drive P.O. Box 3781 Little Rock, AR 72203 (501) 371-2316	Jerry Cooper Independent Living Services Center 5401 Asher Avenue Little Rock, AR 72204 (501) 568-7580 TTY 568-7061

STATE	GRANTEE	CENTER LOCATION
CALIFORNIA	Joseph Klier, Jr. Department of Rehabilitation Program Development Division 830 K. Street Mall Sacramento, CA 95814 (916) 322-6604	Doug Broten C.A.P.H. IL Center 605 W. Home Avenue Fresno, CA 93728 (209) 237-2055
		Annette Rubino IL Resource Center 423 W. Victoria Santa Barbara, CA 93101 (805) 963-1359 TTD 963-0595
		David Buckles The Center for IL of San Gabriel Valley 2231 E. Garvey Avenue West Covina, CA 91790 (213) 339-1276
		Frances Gracechild Resources Blvd. for IL 1230 H. Street Sacramento, CA 95814 (916) 446-3074
		Brenda Premo Dayle McIntosh Center for the Disabled 8100 Garden Grove Blvd. Suite 1 Garden Grove, CA 92644 (714) 898-9571 TTY 892-7070
		Robert Bennett Center for the Independence of the Disabled 875 O'Neil Avenue Belmont, CA 94002 (415) 595-0783
		Norma Vescon Darryl McDaniel ILC., Inc. 14354 Haynes Van Nuys, CA 91401 (213) 988-9525

STATE	GRANTEE	CENTER LOCATION
		Jim West Northern CA IL Center 360 East First Street Chico, CA 95926 (916) 893-8527
COLORADO	David L. Gies Division of Rehabilitation Department of Social Services 524 Social Services Bldg. 1575 Sherman Street Denver, CO 80203 (303) 866-5096	Theresa Preda HAIL 1249 East Colfax Avenue Suite 107 Denver, CO 80218 (303) 831-6381
		Jo Pat Loisen Pueblo Goodwill Industries, Inc. 230 N. Union Avenue Pueblo, CO 81003 (303) 544-9336
		Judy Dixon Center for People with Disabilities Medical Arts Building 1136 Alpine Building, B#3 Boulder, CO 80302 (303) 442-8662
		Ron Halsey Hilltop Rehabilitation Center 1100 Patterson Road Grand Junction, CO 81501 (303) 242-8980 TTY 242-6171
		Wade K. Blank Atlantis Community, Inc. 2200 W. Alameda, Space #18 Denver, CO 80219 (303) 893-8040
		Martha Lee Aaronson The Center on Deafness 4,28 S. Knox Court Denver, CO 80236 (303) 758-1123

STATE	GRANTEE	CENTER LOCATION
CONNECTICUT	Robert A. Voronczak Division of Voc. Rehab. Department of Education 600 Asylum Avenue Hartford, CT 06105 (203) 566-5096	Peter Quinn New Horizons, Inc. 410 Asylum Street Hartford, CT 06103 (203) 249-6275
		Arlene Brown Center for Independent Living Goodwill Industries of CT 164 Ossman Terrance, P.O. Box 3366 Bridgeport, CT 06605 (203) 336-0183 TTY 368-4511
DELAWARE	Robert W. Snider 1/ Division of Voc. Rehab. State Office Bldg., 7th Floor 820 French Street Wilmington, DE 19801 (302) 571-3910	Andrew Vincent Independent Living, Inc. Route 273 Liberty Knoll Apartments Apt. B-1 New Castle, DE 19720 (302) 328-1306
		Carol Shaw Easter Seal Soc. of Del-Mar Adult Development Center Landis Lodge 2915 Newport Gap Pike Wilmington, DE 19808 (302) 995-4481
DISTRICT OF COLUMBIA	Vernon E. Hawkins Rehabilitation Services Administration Commission of Social Services Department of Human Services 605 G. Street, N.W., Washington, D.C. 20001 (202) 727-3227	Don Galloway D.C. Services for IL 1400 Florida Avenue, N.E., #3 Washington, D.C. 20002 (202) 397-4510 (TTY)
FLORIDA	Gerald Alonso Office of Vocational Rehab. Department of Health and Rehabilitative Services 1317 Winewood Blvd., Bldg. #6 Tallahassee, FL 32301 (904) 488-0058 TDD 488-2867	Donna Williams Disability Awareness Now, Inc. (DAWN) 102 NE 10th Avenue Suite 2 Gainesville, FL 32601 (904) 377-5141 TTY 377-5152

1/ Joint project sponsored by both the state general VR agency and the state VR agency for blind or visually handicapped persons.

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STATE	GRANTEE	CENTER LOCATION
		(VACANT) Self-Reliance, Inc. (CIL) [illegible] East Fletcher Avenue Tampa, FL 33612 (813) 977-6368 TTY 977-6338
		Barbara Bernhart-Logan Space Coast Association of the Physically Handicapped (SCAPH) P.O. Box 2027 Satellite Beach, FL 32937 (305) 777-2964 (TDD)
		Joseph Weisz [illegible] Center for IL [illegible] Ocala Road H-4 Tallahassee, FL 32304 (904) 575-9621 (TDD)
		Jay [illegible] Rehabilitation Institute of West Florida [illegible] West Lakeview Avenue Pensacola, FL 32501 (904) 438-3540 TTY 438-3542
		Chip Gagnier, Acting Director Center for Independent Living [illegible] West Central Blvd. Orlando, FL 32801 (305) 843-2253 TTY 843-2297
		[illegible] Center for Survival and Independent Living (C-SAIL) [illegible] Northwest 16th Street Room [illegible] Miami, FL 33125 (305) 547-5444 TTY 547-5446
	Carl McCoy Division of Blind Services 2540 Executive Center Circle, W. Tallahassee, FL 32301 (904) 488-1330	[illegible] C. Seale, Jr. Rural Center for IL P.O. Box 818 Quincy, FL 32351 (904) 875-3235

STATE	GRANTEE	CENTER LOCATION
GEORGIA	Emmanuel Petkas Division of Rehab. Services Department of Human Resources 47 Trinity Avenue, S.W. Room 636-S Atlanta, GA 30334 (404) 656-6495 TTY 656-2913	Jeffrey C. Roulston Atlanta Center for Independent Living 1201 Glenwood Avenue Atlanta, GA 30316 (404) 656-2952 TTY 656-5011
HAWAII	Lorraine Hirokawa Vocational Rehab. and Services for the Blind Div. Department of Social Services P.O. Box 339 Honolulu, HI 96809 (808) 548-4770	Kristin Mills Hawaii Center for IL 677 Ala Moana Blvd., #402 Honolulu, HI 96813 (808) 537-1941 (Island of Oahu) TTY 521-4400
		Mikey Tomita Maui Center for IL 1446 D Lower Main Street Room 105 Wailuku, HI 96793 (808) 242-4966 (Island of Maui) TTY 242-4968
		Chris Nagao Big Island Center for IL 851 Leilani Street Hilo, HI 96720 (808) 935-3777 (Island of Hawaii)
		Gordon Kaluahine, Jr. Independent Living Center P.O. Box 3529 Lihue, HI 96799 (808) 245-4034 (Island of Kauai)
IDAHO	Kenneth Jones Division of Vocational Rehab. State Board of Education 650 W. State, Room 150 Boise, ID 83720 (208) 334-3390	Terry Hawley Dawn Enterprises, Inc. P.O. Box 388 Blackfoot, ID 83221 (208) 785-5890
		A. Gene Christenson Stepping Stone, Inc. 408 South Main Moscow, ID 83843 (208) 833-0543
	Jeananne Whitmer Center of Resources for Independent People (C.R.I.P.) 156 S. Third Pocatello, ID 83201 (208) 232-2747	same

STATE	GRANTEE	CENTER LOCATION
ILLINOIS	Mike Steinhauer Department of Rehab. Services P.O. Box 1587 Springfield, IL 62705 (217) 782-9432	Marca Bristo Access Living 505 N. La Salle Street Chicago, IL 60610 (312) 649-7404 TDD 649-8593
		Kendal Kerns Rockford Access & Mobilization Project, Inc. (RAMP) 1329 N. Main Street Rockford, IL 61103 (815) 968-7467 (V/TTY)
INDIANA	Frances K. Shine Allen County League for the Blind 5400 Fairfield - Suite 210 Fort Wayne, In 46807 (219) 745-5491	same
IOWA	Louise Duvall Iowa Commission for the Blind 4th & Keosauqua Way Des Moines, IA 50309 (515) 283-2601	same
KANSAS	Robin O'Dell Division of Vocational Rehab. Department of Soc. & Rehab. Serv. 2700 West 6th, Biddle Bldg. 2nd Floor Topeka, KS 66606 (913) 296-3911	Mitch Cooper Topeka Resource Center for the Handicapped 421 SE Winfield Topeka, KS 66607 (913) 233-6323 TTY 233-6788
		Robert Mikesic Operation LINK P.O. Box 1016 Hays, KS 67601 (913) 625-2521
	Mona McCoy Independence, Inc. 1910 Haskell Lawrence, KS 66044 (913) 841-0333	same

STATE	GRANTEE	CENTER LOCATION
KENTUCKY	Jeanne Pherson Bureau for the Blind Kentucky Vocational Services 1900 Brownsboro Road Louisville, KY 40206 (502) 893-0211	Betty Gissoni Center for IL for the Blind 1900 Brownsboro Road Louisville, KY 40206 (502) 897-6439
	Eileen Ordover, Acting Center for Accessible Living 835 W. Jefferson Louisville, KY 40402 (502) 5[illegible]-6620 TTY 752-6064	same
LOUISIANA	John Giese Department of Health & Human Resources Office of Human Development P.O. Box 44371 Baton Rouge, LA 70804 (504) 342-2277	Richard Royse New Orleans Center for IL 3308 Tulane Avenue, Suite 220 New Orleans, LA 70119 (504) 821-4981 TTY 821-4982 Shirley Swanson Independent Living Serv. Center 306 Ockley Drive Shreveport, LA 71105 (318) 861-6662
MAINE	Denise Richards Maine IL Center, Inc. 74 Winthrop Street Augusta, ME 04330 (207) 622-5434	same
MARYLAND	James Fitzpatrick Maryland State Dept. of ED Division of Vocational Rehab. Office of Field Operations 200 West Baltimore Street Baltimore, MD 21201 (301) 659-2254	Gloria Carpeneto Baltimore Citizens for Housing for the Disabled, Inc. (BCHD) 2301 Argonne Drive, Box 242 Baltimore, MD 21218 (301) 243-5445 TTY 243-8085
MASSACHUSETTS	John J. Reilly Massachusetts Rehab. Commission Statler Office Bldg. 20 Park Plaza Boston, MA 02116 (617) 727-2170	Robert Williams Boston Center for IL 50 New Edgerly Road Boston, MA 02115 (617) 536-2187

STATE	GRANTEE	CENTER LOCATION
		Edwin (Ted) Abusamra The Center for Living and Working 600 Lincoln Street Worcester, MA 01605 (617) 853-1068
		Charles Carr Northeast IL Center 429 Broadway Lawrence, MA 01840 (617) 687-4288
		Eric Griffin Independence Associates Human Service Center 693 Bedford Street Elmwood, MA 02337 (617) 378-3997
		Patricia Spiller Stavros, Inc. 691 S. East Street Amherst, MA 01002 (413) 256-0473
		Michael Harvey D.E.A.F., Inc. (Development, Evaluation, and Adjustment Facilities) 215 Brighton Avenue Allston, MA 02154 (617) 254-4041
		Ralph Calamari Berkshire Project 496 Tyler Street Pittsfield, MA 01201 (413) 447-7364
		Irene Carpenter The Renaissance Club 721 Branch Street Lowell, MA 01851 (607) 452-3711
	Maureen Ecker Massachusetts Commission for the Blind 110 Tremont Street Boston, MA 02108 (617) 727-5554	same

STATE	GRANTEE	CENTER LOCATION
MICHIGAN	Robert McConnell Department of Education Michigan Rehabilitation Serv. P.O. Box 30010 Lansing, MI 48909 (517) 373-3978	Ron O'Brian Rehabilitation Institute Center for IL 4 East Alexandrine Bicentennial Towers Suite 104 Detroit, MI 48201 (313) 494-9726
		Alan Parmee Center for Handicapper Affairs 1026 East Michigan Lansing, MI 48912 (517) 485-5887 (TTY)
		Jim Magyar Center for IL, Inc. 2568 Packard Road Ann Arbor, MI 48104 (313) 971-0277
		Larry Lopez Cristo Rey Hispanic Handicapper Program 1314 Ballard Street Lansing, MI 48906 (517) 372-4700
		Nancy Jochim Center for Independent Living 3375 Division, South Grand Rapids, MI 49548 (616) 243-0846
		Karen Duckworth Kalamazoo County Center for Independent Living P.O. Box 691 Kalamazoo, MI 49005-1091 (616) 345-1516
		Rebecca Shuren Midland IL Center-ARC P.O. Box 1491 Midland, MI 48640 (517) 631-4439
		Steve Kiviari Oakland Patient Environment Nexus (OPEN) 35 West Huron, Suite 226 Pontiac, MI 48058 (313) 335-3377

STATE	GRANTEE	CENTER LOCATION
		Steve Redmond ARC/Ottawa County 246 S. River #03 Holland, MI 49423 (616) 396-1201
	Glenn Leavitt Commission for the Blind/CIL 309 N. Washington P.O. Box 30015 Lansing, MI 48909 (517) 373-9415	Glen Leavitt Mid Michigan Urban Center for Independent Living Division of Vocational Rehab. 309 N. Washington P.O. Box 30015 Lansing, MI 48909 (517) 373-9415
		Glen Leavitt Northern MI Rural Center for Independent Living 209 W. First Street Suite 102 Gaylord, MI 49735 (517) 732-2448
	John Crews Senior Blind Program 411 G East Genesee Saginaw, MI 48607 (517) 771-1765	John Crews Southeastern Michigan, CIL Commission for the Blind Plaza Bldg., Suite 1139 1200 6th Avenue Detroit, MI 48226 (313) 256-1524
MINNESOTA	Marvin O'Symore Division of Rehabilitation 3rd Floor, Space Center 444 Lafayette St. Paul, MN 55101 (612) 296-9150	William Mallaris Rochester Center for IL, Inc. 1306 Seventh St., N.W. Rochester, MN 55901 (507) 285-1815 TTY 285-1704
		Roger Dixon Rural Enterprises for Acceptable Living, Inc., (REAL) 244 W. Main Street Marshall, MN 56258 (507) 532-2221
		Walter Gilbert METRO Center for IL 1728 University Avenue St. Paul, MN 55104 (612) 646-8342 TTY 646-6048

STATE	SERVICE	CENTER LOCATION
	Dick Strong Minnesota State Services for the Blind Department of Public Welfare 1745 University Avenue St. Paul, MN 55104 (612) 297-1407	same
MISSISSIPPI	John H. Webb Division of Vocational Rehab. P.O. Box 1698 Jackson, MS 39205 (601) 354-6825	John Lee Center for Independent Living P.O. Box 1698 Jackson, MS 39205 (601) 961-4140
MISSOURI	Barbara Bradford Disabled Citizens Alliance for Independence Box 675 Viburnum, MO 65566 (314) 244-3315	same
	Margaret L. Strauss The Whole Person, Inc. 7301 Troost Avenue, Suite 105 Kansas City, MO 64131 (816) 361-0304	same
	David Tyrey IL Center of Mid-MO, Inc. 111 S. Ninth, Suite 211 Columbia, MO 65201 (314) 874-1646	same
	Don L. Gann Missouri Div. of Vocational Rehab. 2401 East McCarty Jefferson City, MO 65101	Max J. Starkloff Paraquad, Inc. 4397 Laclede Avenue St. Louis, MO 63108 (314) 531-3050
MONTANA	Sister Janet Kennedy Montana Independent Living, Inc. 1215 8th Avenue Helena, MT 59601 (406) 442-5755	same
	Wendy Holmes Summit-IL Center 1115 Clark Street Missoula, MT 59801 (406) 728-1630	same

STATE	GRANTEE	CENTER LOCATION
NEBRASKA	Kristine Nolan Clare Central Nebraska Goodwill Industry Goodwill Center for IL 1804 S. Eddy Grand Island, NE 68801 (308) 384-7896	same
	Mike Schafer League of Human Dignity 1423 O Street Lincoln, NE 68508 (402) 474-0820	Nancy Erickson League of Human Dignity Independent Living Center 1423 O Street Lincoln, NE 68508 (402) 474-0158
		Peg Henke League of Human Dignity 700-1/2 W. Benjamin Norfolk, NE 68701 (402) 371-4475
		Kirk Garner League of Human Dignity Handicap Reach Out, Inc. 300 W. Second Street Chadron, NE 69337 (308) 432-3393
NEVADA	Elaine Smith Rehabilitation Division Department of Human Resources 5th Floor, Kinkead Bldg. 505 East King Street Carson City, NV 89710 (702) 885-4470	Edward Buttera CIL, Southern Chapter 2401 W. Bonanza Road, Suite J Las Vegas, NV 89106 (702) 646-0377
		Karen O'Neill Northern Nevada CIL, Inc. 790 Sutro Street Reno, NV 89512 (702) 322-6046
NEW HAMPSHIRE	Bruce A. Archambault Division of Vocational Rehab. 105 Loudon Road Concord, NH 03301 (603) 271-3121	Kenneth Sweet Granite State IL Foundation P.O. Box 410 Goffstown, NH 03045 (603) 669-7242

NEW JERSEY	George R. Chismadia [1] Division of Vocational Rehabilitation Services Department of Labor & Industry John Fitch Plaza P.O. Box 2098 Trenton, NJ 08625 (609) 292-5987	Gordon Anthony Disabled Information Awareness and Living (DIAL) 234 Parker Avenue Clifton, NJ 07011 (201) 472-5540 TTY 472-6329 Eileen Goff Handicapped Independence Program (HIP) Social Service Federation 44 Armory Avenue Englewood, NJ 07631 (201) 568-0817
NEW MEXICO	Terry P. Brigance Division of Vocational Rehab. Department of Education 604 San Mateo Santa Fe, NM 87501 (505) 982-4555	Andrew Winnegar New Vistas IL Center College of Santa Fe St. Michaels Drive Santa Fe, NM 87501 (505) 473-0550 TTY 473-1414
NEW YORK	Greg O'Connor [1] Office of Vocational Rehab. State Education Department 99 Washington Avenue Albany, NY 12234 (518) 473-7620	Burt Danovitz, Ph.D. Allied Resources Center for the Handicapped 1506 Whitesboro Street Utica, NY 13502 (315) 797-4642 Pat Figueroa Center for Independence of the Disabled in New York 853 Broadway, Room 611 New York, NY 10003 (212) 674-2300 Michael Crinnin Arise, Inc. 501 East Fayette Street Syracuse, NY 13202 (315) 472-3171 Richard Manley Westchester County IL Center Office of the Disabled 148 Martine Avenue White Plains, NY 10601 (914) 682-7799 TTY 682-3408

[1] Joint project sponsored by both the State general VR agency and the state VR agency for blind or visually handicapped persons (in part).

STATE	GRANTEE	CENTER LOCATION
		Douglas Usiak Western NY IL Project 3108 Main Street Buffalo, NY 14214 (716) 836-0822
		Darrell L. Jones RCIL 464 South Clinton Avenue Rochester, NY 14620 (716) 546-8490 (TTY)
		Debra L. Hamilton Capital District Center for Independence, Inc. (CDCI) 10 Colvin Avenue Albany, NY 12206 (518) 459-6422 TTY 459-7847
NORTH CAROLINA	Bob H. Philbeck Division of Vocational Rehabilitation Services Department of Human Resources State Office 620 N. West Street, Box 26053 Raleigh, NC 27611 (919) 733-5766 TTY 733-5920	John Rose Metroline IL Center 929 S. College Street Charlotte, NC 28202 (704) 375-3977 (TTY)
NORTH DAKOTA	James O. Fine Division of Vocational Rehab. ND Department of Human Services State Capitol Bismarck, ND 58505 (701) 224-2907	Linda Fessler Center for Independent Living 1007 18th Street, N.W. Mandan, ND 58554 (701) 663-0376
OHIO	G.E. Minteer Ohio Rehab. Services Commission 4656 Heaton Road Columbus, OH 43229 (614) 438-1296;1286	Doris Brennan Services for IL, Inc. 25100 Euclid Ave., #105 Euclid, OH 44117 (216) 731-1529
		Lynn Benjamin Total Living Concepts, Inc. 3333 Vine Street, Suite 101 Cincinnati, OH 45220 (513) 751-1795

STATE	GRANTEE	CENTER LOCATION
OKLAHOMA	Helen Kutz United Cerebral Palsy of Cleveland County 601 North Porter Normand, OK 73071 (405) 321-3203 (TTY)	same
	Roland W. Sykes Physically Limited, Inc. 1724 East 8th Street Tulsa, OK 74104 (918) 592-1235 (TTY)	same
OREGON	Tom Huffsmith Vocational Rehab. Division Department of Human Resources 2045 Silverton Road, N.E. Salem, OR 97310 (503) 378-3830	Vikki Rennick Tri-County IL Program, Inc. 8213 S.E. 17th Ave. Portland, OR 97212 (503) 249-1225
		Mary Alice Brown Community Services of Lane County 2621 Agusta Street Eugene, OR 97403 (503) 485-6340
		John Blarjeske Nuerological Services Center Good Samaritan Hospital 1015 S.W. 22nd Avenue Portland, OR 97210 (503) 229-7348
	Charles Young Oregon Commission for the Blind 535 S.E. 12th Avenue Portland, OR 96214 (503) 238-8380	Claude Garvin Volunteer Braille Service, Inc. 1931 N.W. Flanders Portland, OR 97209 (503) 222-1472
PENNSYLVANIA	Chris Forbrich 1/ PA Office of Vocational Rehabilitation Labor and Industry Bldg Room 1320 Seventh and Forster Streets Harrisburg, PA 17120 (717) 787-5548	Barbara Donnelly Resources for Living Independent (RLI) 4721 Pine Street Philadelphia, PA 19143 (215) 476-2217 TTY 476-2291

1/ Joint project sponsored by both the State general VR agency and the State VR agency for blind or visually handicapped persons.

STATE	GRANTEE	CENTER LOCATION
		Judith Barricella Harmarville Rehab. Center. Inc. Center for Independent Living P.O. Box 11460 Guys Run Road Pittsburgh, PA 15238 (412) 781-5700
		Greg Meehl Erie Independence House, Inc. Center for Independent Living 956 W. Second Street Erie, PA 16507 (814) 459-6161
		Irene Osborne Nevil Institute for Rehab. Serv. 919 Walnut Street, Room 400 Philadelphia, PA 19107 (215) 627-3501
PUERTO RICO	Luis A. Bonilla Vocational Rehab. Program P.O. Box 1118 Hato Rey, PR 00919 (809) 725-1792	Maria Rosa Iturregui Rio Piedras Rehabilitation Center P.O. Box 1118 Hato Rey, PR 00919 (809) 725-1792
RHODE ISLAND	William A. Messore 1/ Social & Rehabilitative Service Vocational Rehabilitation 40 Fountain Street Providence, RI 02903 (401) 421-7005	Herbert Lumbert Parapledic Association of RI IL Program 120 Dudley Street Providence, RI 02905 (401) 331-4447
		Peter Holden Blackstone Valley Center for Retarded Citizens 115 Manton Street Pawtucket, RI 02861 (401) 727-0510
		Ann Silveria Providence MH Center 100 Fountain Street Providence, RI 02903 (401) 274-7111

1/ Joint project sponsored by both the State general VR agency and the State VR agency for blind or visually handicapped persons (in part).

STATE	GRANTEE	CENTER LOCATION
SOUTH CAROLINA	Paul G. Knight Vocational Rehabilitation Department Independent Living Program P.O. Box 4945 Columbia, SC 29240 (803) 758-7143	Betty Easler Life Exploration and Alternatives Program 1400 Boston Avenue West Columbia, SC 29169 (803) 758-8731
SOUTH DAKOTA	John E. Madigan South Dakota Department of Vocational Rehabilitation Richard F. Kneip Building 700 Illinois Street, N. Pierre, SD 57501 (605) 773-3125	David Miller Prairie Freedom Center for Disabled Independence 800 West Avenue, N. Sioux Falls, SD 57104 (605) 339-6581
TENNESSEE	O.E. Reese Division of Vocational Rehab. 1808 West End, Room 1400 Nashville, TN 37203 (615) 741-2521	Fred Dinwiddie Easter Seal Center for IL 1177 Poplar Avenue Memphis, TN 38105 (901) 726-6404
TEXAS	Ted M. Thayer Texas Rehabilitation Commission Division of Vocational Rehab. 118 E. Riverside Drive Austin, TX 78704 (512) 445-8285	Lon Grazier Houston Center for IL 6910 Fannin Street, Suite #120 Houston, TX 77030 (713) 795-4252 TTY 795-5261
		Robert Simpson Austin Resource Center for IL 2818 San Gabriel Austin, TX 78705 (512) 473-2684 TTY 473-2688
		Marshall Levett El Paso Opportunity Center for the Handicapped (EPOCH) 8929 Viscount, Suite 101 El Paso, TX 79925 (915) 591-0680 (TTY)
		Bernice Cantu San Antonio IL Services (SAILS) 2803 E. Commerce The Barbara Jordan Center San Antonio, TX 78203 (512) 226-0054 (TTY)

STATE	GRANTEES	CENTER LOCATION
	Robert Packard Texas Commission for the Blind Field Services Division P.O. Box 12866 Austin, TX 78711 (512) 475-1784	John Humbart Independent Living Program 2201 Sherwood Way Suite 118 San Angelo, TX 76901 (915) 949-4601
		Juanita Holloway IL Rehabilitation Program State Commission for the Blind 8100 Washington, Suite 119 Houston, TX 77007
		Adele Baker IL Rehabilitation Program State Commission for the Blind 4410 Dillion Land #20 Corpus Cristi, TX 78 15 (512) 854-2361
UTAH	Gary LaComb Division of Rehabilitation Serv. Utah State Office of Education 250 East Fifth South Salt Lake City, UT 84111 (801) 533-5991	Willard Smith Utah Independent Living Center, Inc. 764 South 00 West Salt Lake City, UT 84101 (801) 359-2457
VERMONT	Stanley Greenburg Vermont Association for the Blind 37 Elmwood Avenue Burlington, VT 05401 (802) 863-1358	same
	Sid Davis Agency of Human Services Division of Vocational Rehab. 103 South Main Street Waterbury, VT 05676 (802) 241-2194	Jean Mankowski Vermont Center for Independent Living 174 River Street Montpelier, VT 05602 (802) 229-0501
VIRGIN ISLANDS	Felecia A. Brownlow Virgin Islands Association for Independent Living, Inc. P.O. Box 3305 Charlotte Amalie St. Thomas, VI 00801 (809) 774-2740	same

STATE	GRANTEE	CENTER LOCATION
VIRGINIA	John Wade Virginia Department of Rehabilitative Services 4901 Fitzhugh Avenue P.O. Box 11045 Richmond, VA 23230 (804) 257-0281	Amy Cotraweet Richmond Center for IL 6118 Jahnke Road Richmond, VA 23225 (804) 233-2033
		Carol Summers Woodrow Wilson Center for Independent Living Fishersville, VA 22939 (703) 885-9851
		John Chappell, Jr. Endependence Center of Tidewater 855 W. Brambleton Ave. Norfolk, VA 23510 (804) 623-8069 (804) 623-8092
		Tony Young Endependence Center of N. Va. 4214 9th Street, North Arlington, VA 22203 (703) 535-ECNV
	Audrey Davis Virginia Department for the Visually Handicapped 397 Azalea Avenue Richmond, VA 23227 (804) 264-3112	Martha Lassiter VA Dept. of Visually Handicapped Independent Living Center 1809 Staples Mill Road, Suite 101 Richmond, VA 23230 (804) 257-0030
		Betsy Smithka ILC for Multi. Handicapped Blind 2300 9th Street, S. #203 Arlington, VA 22204 (703) 979-3415
		Debra Persinger Department for the Visually Handicapped Independent Living Center 1030 S. Jefferson Street Suite 200 Roanoke, VA 24016 (703) 982-7122
WASHINGTON	Robert Thurston Division of Vocational Rehab. Dept. of Social & Health Serv. OB 21C Olympia, WA 98504 (206) 753-2756	Della Shafer Community Home Health Center 200 W. Thomas Seattle, WA 98109 (206) 282-5048

STATE GRANTEE CENTER LOCATION

Tracy Harris
Community Service Center
for Deaf & Hard of Hearing
914 E. Jefferson
Room 329
Seattle, WA 98122
(206) 322-4996 (V/TTY)

Jack Gerringer
Good Samaritan Hospital &
Rehabilitation Center
408 14th Avenue, S.E.
Puyallup, WA 98371
(206) 845-1759

Ellen Repcoch
Spokane Cnty of Comm. Serv. Dept.
Broadway Center Building
N. 721 Jefferson, Suite 403
Spokane, WA 99260
(509) 456-5722

Robert Rourke
Kittitas Community Action
Council, Inc.
115 W. 3rd Street
Ellensburg, WA 98926
(509) 925-1448

Lonnie Davis
University of Puget Sound
Law School
Norton Clapp Center
949 Market St., Suite 366
Tacoma, WA 98402
(206) 756-3480

Karen Veon
Greater Lake Community
Health Center
9108 Lakewood Drive, SW
Tacoma, WA 98499
(206) 594-0933

Jeanne Dockham
Coalition of Handicapped
Organizations
3127 E. Evergreen Blvd.
Vancouver, WA 98661
(206) 696-6068
TTY 696-6070

STATE	GRANTEE	CENTER LOCATION
		(VACANT) Legal Advocacy Center 914 E. Jefferson, Room 326 Seattle, WA 98122 (206) 324-5782
WEST VIRGINIA	Linel Parker State Board of Voc. Rehab. Division of Vocational Rehab. State Capitol Charleston, WV 25305 (304) 348-9130	Ira Herman Huntington Center for IL, Inc. 914 1/2 Fifth Avenue Huntington, WV 25701 (304) 525-3324
	Karen Newton Coordinating Council for IL, Inc. Box 677 Morgantown, WV 26507 (304) 599-3636 TTY 598-2424	same
	Thelma H. Hall Multi-County Community Action Against Poverty, Inc. 718 Morris Street, P.O. Box 3228 Charleston, WV 25332 (304) 344-3453	John R. Adkins Appalachian CIL, Inc. 1427 Lee Street Charleston, WV 25301 (304) 342-6328 (TTY)
WISCONSIN	Duane Zimdars Division of Vocational Rehab. P.O. Box 7852 Madison, WI 53703 (608) 266-1134	Eileen Weckley Access to Independence, Inc. 1954 E. Washington Ave. Madison, WI 53704 (608) 251-7575
		William Hatcher Southeastern Wisconsin Center for IL, Inc. (SEWCIL) 1545 S. Layton Blvd., Room 524 Milwaukee, WI 53215 (414) 643-0910
		Gretchen Russert Stout Program for IL-Voc. Development Center University of Wisc-Stout Menomonie, WI 54751 (715) 232-2293 (V/TTY)

STATE	GRANTEE	CENTER LOCATION
WYOMING	Dave Andrews Division of Vocational Rehab. Dept. of Health & Soc. Services 326 Hathaway Building Cheyenne, WY 82002 (307) 777-7385	Robert Carton Independent Living Rehab. 550 Rancho Road Casper, WY 82601 (307) 577-11016

U. S. DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION
AND REHABILITATIVE SERVICES
REHABILITATION SERVICES ADMINISTRATION
WASHINGTON, D.C. 20202

INFORMATION MEMORANDUM
RSA-IM-83-35
June 21, 1983

TO: STATE REHABILITATION AGENCIES (GENERAL)
STATE REHABILITATION AGENCIES (BLIND)
RSA REGIONAL COMMISSIONERS
RSA SENIOR STAFF

SUBJECT: Transmittal of Report: "Caseload Statistics, State Vocational Rehabilitation Agencies, Fiscal Year 1982"

The attached report presents a statistical summary of caseload activity in State vocational rehabilitation agencies during Fiscal Year 1982 based on Form RSA-113, The Quarterly Caseload/Expenditure Report.

As in recent years, overall caseload activity for Fiscal Year 1982 was characterized by declines in most measures. Active cases served declined for the seventh year in a row and the 226,924 cases closed rehabilitated during this fiscal year represented the fewest number of successful case closures recorded since Fiscal Year 1968.

Activity among severely disabled cases was down for the third consecutive year during Fiscal Year 1982. However, these cases continued to account for a larger proportion of the total active cases available.

There are four agency tables included in this year's report. They show the numbers of total and "severe" cases rehabilitated and served. The remaining tables indicate national trends only. For the first time in many years you will find a table which presents, on a national basis, the number of cases rehabilitated and served per 100,000 population residing in the United States for Fiscal Year 1971 through Fiscal Year 1982. This measure, too expresses the decline in caseload activity. We returned to this method of computing the rates to allow for continuity in comparison from one decade to the next. Finally, you will also find a series of seven charts interspersed throughout the report.

We hope this report, like the ones in the past, will serve as an important informational source of the State-Federal program for vocational rehabilitation.

George A. Conn
Commissioner of Rehabilitation Services

Attachments

cc:
CSAVR

Rehabilitation Services Administration
Office of Program Operations
Basic State Grants Branch
June, 1983

Caseload Trends Through Fiscal Year 1982

INTRODUCTION

Fiscal Year 1982 was a year in which the number of persons in State agency caseloads, as measured in a variety of ways, continued to decrease and, in most instances, decrease sharply. Compared to Fiscal Year 1981, fewer persons applied for services, fewer were accepted for services, fewer were rehabilitated and served, and fewer were still in receipt of services as Fiscal Year 1982 ended. Even cases of severely disabled persons were not spared from the overall decline, although their losses were not as steep as those for the non-severely disabled population. The severely disabled continued to account for increasing proportions of clients in State agency caseloads. In terms of total caseload volumes, the State-Federal program is no larger than it was about 12 to 14 years ago. For caseloads of severely disabled persons, volumes in Fiscal Year 1982 resembled those five years earlier.

REHABILITATIONS

In Fiscal Year 1982, 226,924 disabled persons were vocationally rehabilitated in the State-Federal program. This result represented (a) a decline of 11.3 percent from the 255,881 rehabilitations attained in Fiscal Year 1981, (b) the fewest successful closures in 14 years, and (c) the seventh decline in the last eight years following the peak performance of 361,138 rehabilitations in Fiscal Year 1974.

Rehabilitations of severely disabled persons in Fiscal Year 1982 numbered 129,866. This accomplishment represented (a) a loss of 6.2 percent from the 138,380 rehabilitations effected in Fiscal Year 1981, (b) the fewest such successes in five years, and (c) the third year in a row of a decline in this key target group of disabled persons after a high of 143,375 rehabilitations was reached in Fiscal Year 1979. The percentage of all persons rehabilitated in Fiscal Year 1982 who were severely disabled rose to 57.2 percent, the highest ever recorded.

PERSONS SERVED

In Fiscal Year 1982, there were 958,537 persons who received vocational rehabilitation services. This finding represented (a) a decline of 7.7 percent from the 1,038,232 persons served in Fiscal Year 1981, (b) the smallest such number recorded in the last 12 years, (c) the first time in 12 years that the number served fell below one million persons, and (d) the seventh decline in as many years since the high point of 1,244,338 persons served was reached in Fiscal Year 1975.

The number of severely disabled persons served totalled 571,542 in Fiscal Year 1982. This was (a) 4.9 percent below the total of 600,727 for the prior fiscal year, (b) the fewest served in five years and (c) the third consecutive decline in as many years after a high of 611,994 was established in Fiscal Year 1979. Of all persons served in Fiscal Year 1982, 59.6 percent were severely disabled, the highest such proportion recorded.

NEW APPLICATIONS FOR SERVICES

The number of persons newly applying for rehabilitation services was 564,443 in Fiscal Year 1982. This was (a) a loss of 11.6 percent from the 638,342 new applicants the year before, (b) the fewest number of new applicants in 14 years and (c) the sixth decline in the last seven years after the all-time high of 885,737 was experienced in Fiscal Year 1975.

ACCEPTANCES FOR SERVICES

The number of persons accepted for vocational rehabilitation services in Fiscal Year 1982 was 333,439. This was (a) a loss of 10.7 percent from the 373,310 newly accepted clients in the prior year, (b) the fewest number accepted into the program since Fiscal Year 1968, and (c) the sixth time in the last seven years of a decreasing trend after a high of 536,491 acceptances occurred in Fiscal Year 1975.

Severely disabled persons among those newly accepted for services totalled 200,601 in Fiscal Year 1982. This was (a) a loss of 10.6 percent from the 224,309 acceptances in the previous year, (b) the fewest number of new active cases recorded in the seven years for which data are available and (c) the third consecutive decrease after a high of 236,287 acceptances occurred in Fiscal Year 1979. The proportion of new active cases that were of severely disabled persons remained at 60 percent for the second year in a row.

APPLICANTS STILL IN PROCESS

The number of applicants whose eligibility for services was still being evaluated as of September 30, 1982 was 232,243. This represented (a) a decrease of 9.8 percent from the 257,610 persons in evaluation on the same date one year earlier, (b) the fewest number of end-of-year applicants in 13 years and (c) the fifth decline in the last seven years after the highest backlog of applicants of 357,653 was attained at the end of Fiscal Year 1975.

CLIENTS STILL RECEIVING REHABILITATION SERVICES

The number of persons still in receipt of rehabilitation services on September 30, 1982 was 589,038. This represented (a) a loss of 5.7 percent from the 624,669 persons receiving services on September 30, 1981, (b) the fewest number of end-of-year cases in 12 years and (c) the seventh consecutive decline since the highest backlog of 778,448 persons still receiving services was reached at the end of Fiscal Year 1975.

The number of severely disabled persons still receiving services on September 30, 1982 was 351,109. This was (a) a decrease of 4.3 percent from the 366,883 severely disabled persons in receipt of services on the same date one year earlier, (b) the fewest number of end-of-year cases in six years and (c) the third reduction in a row since the highest backlog of 381,079 cases of severely disabled persons occurred at the end of Fiscal Year 1979.

NEW EXTENDED EVALUATION CASES

There were 28,778 new extended evaluation cases received by State agencies during Fiscal Year 1982. This figure was (a) 18.3 percent below the 35,224 cases received during the previous fiscal year, and (b) the fewest number of new extended evaluation cases recorded since Fiscal Year 1972. This decline in new extended evaluation cases, more than likely, stemmed from the loss in Trust Funds monies which were often used to serve such cases.

ACCEPTANCE AND REHABILITATION RATES

More than half, 56.1 percent, of the applicant and extended evaluation cases processed during Fiscal Year 1982 were determined eligible for VR services. This rate represented (a) a slight increase from the prior year when 54.8 percent of the cases processed were accepted, and (b) the second lowest acceptance rate recorded since Fiscal Year 1972.

Overall, roughly, three out of every five (61.4 percent) active cases closed during Fiscal Year 1982 were closed rehabilitated. This was the lowest overall rehabilitation rate reported since Fiscal Year 1946. The rehabilitation rate for severely disabled cases closed in Fiscal Year 1982 was 58.9 percent. This was the lowest rehabilitation rate recorded for such cases in the seven years for which data are available.

RATES PER 100,000 POPULATION

Another way of measuring the decline in the impact of the VR program is to look at the rates per 100,000 population. Nationally, the number of persons rehabilitated by State VR agencies for every 100,000 persons residing in the United States has declined from as much as 170 in Fiscal Year 1973 to only 97 in Fiscal Year 1982. The national rate of active cases served per 100,000 population in Fiscal Year 1982 was 409. This was the seventh consecutive decline recorded for this caseload item since the high of 576 occurred in Fiscal Year 1975.

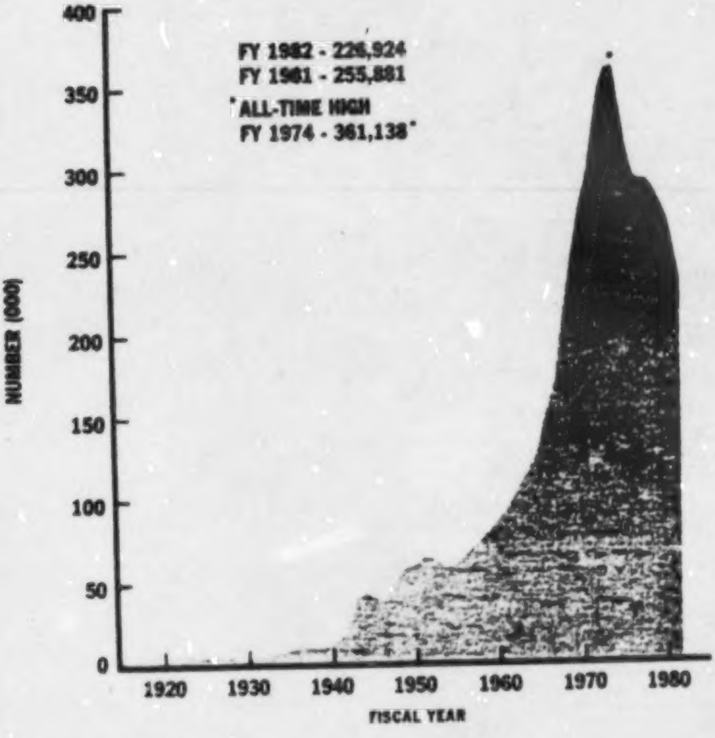
CAUSES OF CASELOAD DECLINES

The declines in caseload volumes in recent years are attributed to (a) decreases in the purchasing power of the rehabilitation dollar including the near total loss of funding from Social Security monies in Fiscal Year 1982 and (b) continued emphasis in providing services to the severely disabled for whom rehabilitation efforts are more costly. It is estimated that the purchasing power of funds available to State rehabilitation agencies declined by 29.2 percent in the relatively short period from 1979 to 1982. In dollar terms, the loss was approximately $361 million. (In actual as opposed to constant dollars, the loss was only $72 million, or 5.8 percent.) Of the $361 million decrease in purchasing power between 1979 and 1982, $186 million is attributed to the impact of inflation on Federal and State monies expended under Basic Support, and $175 million to the cutoff of funding from Social Security and a small Innovation and Expansion grant program. It was subsequent to Fiscal Year 1979 that numbers of severely disabled persons accepted into, rehabilitated by, and served by the rehabilitation program began to decline.

SECTION I

TOTAL CASELOAD ACTIVITY

FIGURE A
NUMBER OF PERSONS REHABILITATED, FY 1921 - 1982



FY 1982 - 226,924
FY 1981 - 255,881
*ALL-TIME HIGH
FY 1974 - 361,138*

Table 1 - Number of active cases served and persons rehabilitated by State vocational rehabilitation agencies, Fiscal Years 1921 - 1982

Fiscal Year	Cases Served	Persons Rehabilitated	Fiscal Year	Cases Served	Persons Rehabilitated
1982	958,537	226,924			
1981	1,038,232	255,881	1951	231,544	66,193
1980	1,095,139	277,136	1950	255,724	59,597
1979	1,127,551	288,325	1949	216,997	58,020
1978	1,167,991	294,396	1948	191,063	53,131
1977	1,204,487	291,202	1947	170,143	43,880
1976	1,238,446	303,328	1946	169,796	36,106
1975	1,244,338	324,039	1945	161,050	41,925
1974	1,201,661	361,138	1944	145,059	43,997
1973	1,176,445	360,726	1943	129,207	42,618
1972	1,111,045	326,138	1942	91,572	21,757
1971	1,001,660	291,272	1941	78,320	14,579
1970	875,911	266,975	1940	65,624	11,890
1969	781,614	241,390	1939	63,575	10,747
1968	680,415	207,918	1938	63,666 1/	9,844
1967	569,907	173,594	1937		11,091
1966	499,464	154,279	1936		10,338
1965	441,332	134,859	1935		9,422
1964	399,852	119,708	1934		8,062
1963	368,696	110,136	1933		5,613
1962	345,635	102,377	1932		5,592
1961	320,963	92,501	1931		5,184
1960	297,950	88,275	1930		4,605
1959	280,384	80,739	1929		4,645
1958	258,444	74,317	1928		5,012
1957	238,582	70,940	1927		5,092
1956	221,128	65,640	1926		5,604
1955	209,039	57,981	1925		5,825
1954	211,219	55,825	1924		5,654
1953	221,849	61,308	1923		4,530
1952	228,490	63,632	1922		1,898
			1921		523

1/ Data prior to 1938 not available

Table 1. — Number of cases in caseloads of State vocational rehabilitation agencies during Fiscal Years 1972 - 1982

Fiscal Year	Applicants and Active Cases		Active Caseload Only	
	Number of Cases (Statuses 02-30)	Percent Change From Previous Year	Number of Cases (Statuses 10-30)	Percent Change From Previous Year
1982	1,473,313	- 9.7	958,537	- 7.7
1981	1,631,167	- 5.7	1,038,238	- 5.2
1980	1,728,987	- 1.3	1,096,139	- 2.9
1979	1,751,862	- 3.5	1,127,351	- 3.5
1978	1,813,944	- 2.7	1,167,991	- 3.0
1977	1,866,707	- 3.0	1,204,487	- 2.7
1976	1,923,068	- 0.7	1,238,446	- 0.5
1975	1,937,872	+ 1.1	1,244,338	+ 3.6
1974	1,824,543	+ 6.2	1,201,061	+ 2.1
1973	1,798,132	+ 1.4	1,176,443	+ 5.9
1972	1,706,110	+ 9.9	1,111,063	+10.9

FIGURE B

NUMBER OF PERSONS REHABILITATED AND NOT REHABILITATED, AND REHABILITATION RATES, FY 1972 - 1982

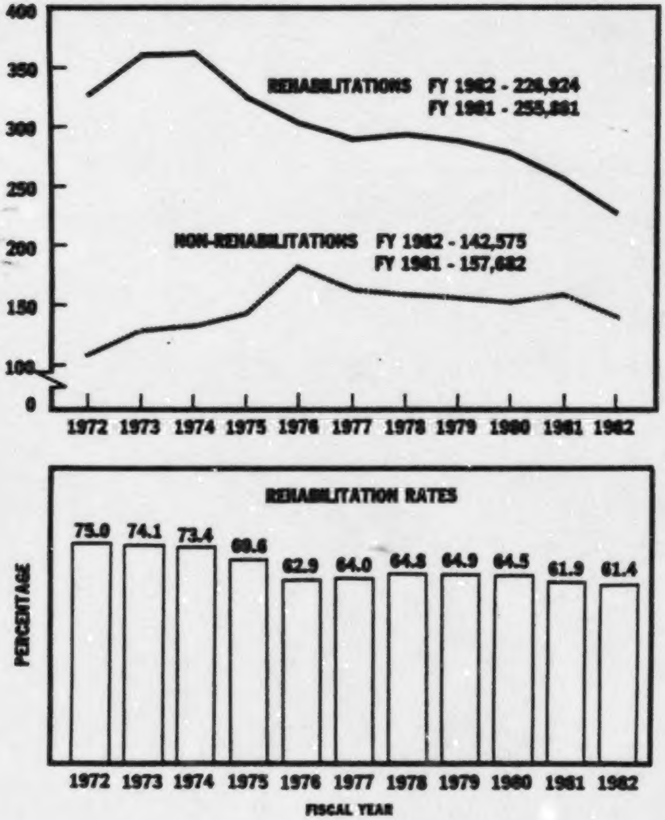


Table 3 — Number of persons rehabilitated and not rehabilitated by State vocational rehabilitation agencies, Fiscal Years 1972 - 1982

Fiscal Year	Persons Rehabilitated		Persons Not Rehabilitated		Rehabilitation Rate 1/
	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year	
1982	226,924	-11.3	142,575	- 9.6	61.4
1981	255,881	- 7.7	157,682	+ 3.3	61.9
1980	277,136	- 3.9	152,672	- 2.3	64.5
1979	288,325	- 2.1	156,258	- 2.2	64.9
1978	294,396	+ 1.1	159,846	- 2.4	64.8
1977	291,202	- 4.0	163,706	- 8.6	64.0
1976	303,328	- 6.4	179,139	+26.3	62.9
1975	324,039	-10.3	141,851	+ 8.4	69.6
1974	361,138	+ 0.1	130,871	+ 3.9	73.4
1973	360,726	+10.6	125,991	+15.8	74.1
1972	326,138	+12.0	108,784	+12.5	75.0

1/ Rehabilitation rates show the number of persons rehabilitated as a percent of all active case closures, whether rehabilitated or not.

FIGURE C

NUMBER OF APPLICANTS ACCEPTED AND NOT ACCEPTED FOR VOCATIONAL REHABILITATION SERVICES, AND ACCEPTANCE RATES, FY 1972 - 1982

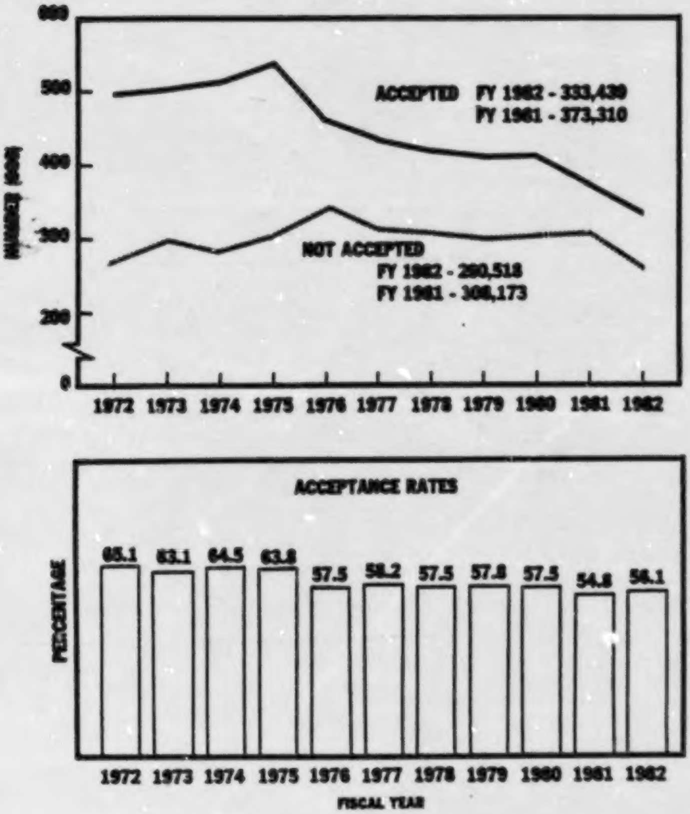


Table 4 — Number of applicant and extended evaluation cases accepted and not accepted for VR services by State vocational rehabilitation agencies, Fiscal Years 1972 - 1982

Fiscal Year	Applicants Accepted		Applicants Not Accepted		Acceptance Rate 1/
	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year	
1982	333,439	-10.7	260,518	-15.5	56.1
1981	373,330	- 9.5	308,173	+ 1.2	54.8
1980	412,356	+ 0.2	304,535	+ 1.1	57.5
1979	411,560	- 1.9	301,077	- 2.8	57.8
1978	419,380	- 3.6	309,624	- 0.9	57.5
1977	435,164	- 5.3	312,515	- 7.9	58.2
1976	459,680	-14.0	339,494	+12.1	57.5
1975	534,491	+ 4.6	302,942	+ 7.7	63.8
1974	511,226	+ 1.6	281,376	- 4.4	64.5
1973	503,318	+ 1.3	294,271	+10.5	63.1
1972	496,680	+ 6.1	266,312	+ 8.0	65.1

1/ Acceptance rates show the number of cases accepted for VR services as a percent of all applicant and extended evaluation cases accepted and not accepted.

FIGURE D

NEW APPLICANTS AND NEW ACTIVE CASES DURING FY 1972-1982

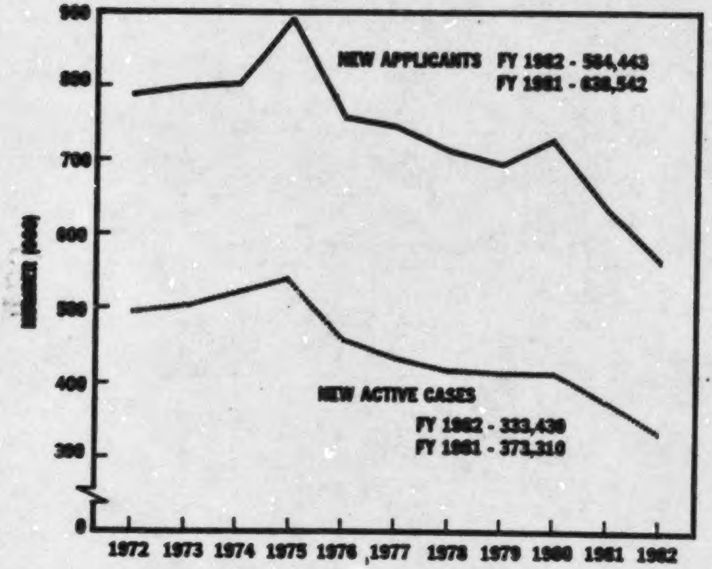


Table 5 -- Number of new applicants, new extended evaluation cases and new active cases in the caseloads of State vocational rehabilitation agencies during Fiscal Years 1972 - 1982

Fiscal Year	New Applicants (Status 02)		New Extended Evaluation Cases (Status 06)		New Active Cases (Status 10)	
	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year
1982	564,463	-11.6	28,770	-18.3	333,439	-10.7
1981	638,542	-11.7	35,224	-15.0	373,310	- 9.5
1980	722,847	+ 3.6	41,426	+ 1.5	412,356	+ 0.2
1979	697,873	- 2.4	40,843	- 1.0	411,560	- 1.9
1978	715,367	- 4.2	41,240	- 1.7	419,590	- 3.6
1977	746,377	- 2.3	41,940	+ 8.1	435,144	- 5.3
1976	763,724	-13.8	38,792	- 7.3	459,620	-14.0
1975	885,737	+ 9.9	41,848	+28.5	534,491	+ 4.6
1974	806,000	+ 1.2	32,536	+ 6.8	511,226	+ 1.6
1973	796,116	+ 1.3	30,486	+ 6.6	503,318	+ 1.3
1972	786,117	+ 7.8	28,307	+12.0	496,680	+ 6.1

Table 6 - Number of applicant, extended evaluation and active cases remaining at the end of the fiscal year in caseloads of State vocational rehabilitation agencies, Fiscal Years 1972 - 1982

Fiscal Year	Total Cases Remaining (Statuses 02 - 24)		In Applicant Status (Status 02)		In Extended Evaluation (Status 06)		In Active Statuses (Statuses 10 - 24)	
	Number	Percent Change From Previous Year	Number	Percent Change from previous year	Number	Percent Change From Previous Year	Number	Percent Change From Previous Year
1982	843,301	- 7.3	232,245	- 9.8	22,013	-18.9	589,038	- 5.7
1981	909,431	- 8.6	257,610	-13.3	27,152	-15.6	624,669	- 6.1
1980	994,654	- 1.1	297,148	+ 1.9	32,175	+ 2.1	665,331	- 2.6
1979	1,006,202	- 4.3	291,730	- 4.5	31,506	- 2.9	682,966	- 4.3
1978	1,051,698	- 4.3	305,514	- 3.5	32,435	- 1.8	713,749	- 4.8
1977	1,099,284	- 0.3	316,662	+ 0.4	33,043	+ 4.7	749,579	- 0.8
1976	1,103,088	- 5.6	315,549	-11.8	31,560	- 4.2	755,979	- 2.9
1975	1,169,040	+ 1.1	357,653	+12.4	32,939	+41.9	778,448	+ 9.7
1974	1,051,160	+ 3.3	318,297	+ 4.1	23,211	+ 7.9	709,652	+ 2.9
1973	1,017,144	+ 1.2	305,902	- 0.8	21,514	+ 5.3	689,728	+ 2.0
1972	1,004,876	+ 9.6	308,331	+ 8.0	20,422	+12.8	676,123	+10.2

Table 7. – Selected Caseload Volumes: Fiscal Year 1982 vs. Fiscal Year 1981 and All-Time High

Caseload Measure	Fiscal Year		Percent change: 82 vs. 81	All Time High		
	1982	1981		Fiscal Year	Number	Percent change: 82 vs. high
Total applicants	821,332	934,209	-12.1%	1975	1,204,262	-31.8%
New applicants	564,443	638,542	-11.6	1975	885,737	-36.3
Applicants on hand, end of year	232,245	257,610	- 9.8	1975	357,653	-35.1
Total active cases served	958,537	1,038,232	- 7.7	1975	1,244,330	-23.0
New active cases	333,439	373,310	-10.7	1975	534,491	-37.5
Rehabilitations	226,924	255,881	-11.3	1974	361,138	-37.2
Non-rehabilitations	142,575	157,682	- 9.6	1976	179,139	-20.4
Active cases on hand, end of year	589,038	624,669	- 5.7	1975	778,448	-24.3
Severe active cases served	571,542	600,727	- 4.9	1979	611,994	- 6.6
New severe active cases	200,601	224,309	-10.6	1979	226,287	-11.4
Severe rehabilitations	129,866	138,300	- 6.2	1979	143,375	- 9.4
Severe non-rehabilitations	90,567	95,462	- 5.1	1981	95,462	- 5.1
Severe active cases on hand, end of year	351,109	366,886	- 4.3	1979	381,078	- 7.9

Table 8 - Number of persons rehabilitated and served by State vocational rehabilitation agencies per 100,000 population, 1/ Fiscal Years 1971-1982

Fiscal Year	Resident Population 2/(mil)	Rehabilitations		Active Cases Served	
		Number 3/	Rate per 100,000 population	Number 3/	Rate per 100,000 population
1982	229.3	222,940	97	936,543	409
1981	227.2	251,483	110	1,014,518	447
1980	224.6	272,204	121	1,069,853	476
1979	222.1	283,185	127	1,101,015	496
1978	219.8	289,531	132	1,141,024	519
1977	217.6	286,906	132	1,177,993	541
1976	215.5	297,147	138	1,209,791	561
1975	213.3	318,251	149	1,214,585	570
1974	211.4	355,528	168	1,172,906	555
1973	209.3	355,614	170	1,150,772	550
1972	206.8	321,612	156	1,089,825	527
1971	204.0	288,158	141	984,982	483

1/ Rates are based on the estimated total resident population on July 1 of each fiscal year except for Fiscal Years 1971 and 1981 which are based on the Decennial Census as of April 1, 1970 and 1980, respectively. Source: U.S. Bureau of the Census, "Current Population Reports," series P-25, Nos. 802 and 903.

2/ Resident population does not include information from Puerto Rico or any of the outlying territories.

3/ Excludes data from Puerto Rico, Virgin Islands, Guam, American Samoa, Trust Territories of the Pacific Islands and Northern Mariana Islands.

Table 9. — Number of applicant, extended evaluation and active cases in State vocational rehabilitation agencies, percent change and percent distribution, Fiscal Years 1981 - 1982

Caseload item	Fiscal Year		Percent Change	Percent distribution Fiscal Year	
	1982	1981		1982	1981
Applicants (02)					
Number available	821,332	934,209	-12.1	100.0	100.0
On hand, Oct. 1	256,889	295,667	-13.1	31.3	31.6
New since Oct. 1	564,443	638,542	-11.6	68.7	68.4
Number processed	589,087	676,590	-12.9	71.7	72.4
Accepted for VR (10)	317,461	354,041	-10.3	38.7	37.9
Accepted for EE (06)	28,778	35,224	-18.3	3.5	3.8
Not accepted for VR or EE (08)	242,848	287,324	-15.5	29.6	30.7
Total on hand, Sept. 30	232,245	257,619	- 9.8	28.3	27.6
Extended evaluation cases (06)					
Number available	55,661	67,260	-17.2	100.0	100.0
On hand, Oct. 1	26,883	32,036	-16.1	48.3	47.6
New since Oct. 1	28,778	35,224	-18.3	51.7	52.4
Number processed	33,648	40,108	-16.1	60.5	59.6
Accepted for VR (10)	15,978	19,269	-17.1	28.7	28.6
Not accepted for VR (08)	17,670	20,839	-15.2	31.7	31.0
Total on hand, Sept. 30	22,013	27,152	-18.9	39.5	40.4
Active cases (10-30)					
Number available 1/	958,337	1,038,232	- 7.7	100.0	100.0
On hand, Oct. 1	624,898	664,922	- 6.0	65.2	64.0
New since Oct. 1	333,439	373,310	-10.7	34.8	36.0
Number closed	369,499	413,563	-10.7	38.5	39.8
Rehabilitated (26)	226,924	255,881	-11.3	23.7	24.6
Not rehabilitated (28)	104,615	116,156	- 9.9	10.9	11.2
Not rehabilitated (30)	37,960	41,526	- 8.6	4.0	4.0
Total on hand, Sept. 30	588,838	624,669	- 5.7	61.5	60.2

1/ Active cases served.

SECTION II

SEVERELY DISABLED CASELOAD

ACTIVITY

Table 18 - Severely disabled clients in the active caseloads of State vocational rehabilitation agencies, Fiscal Years 1981 - 1982

Caseload Item	Fiscal Year 1982				Fiscal Year 1981			
	All clients	Severely disabled			All clients	Severely disabled		
		Number	Percent of total	Percent Change vs. FY 1981		Number	Percent of total	Percent Change vs. FY 1980
Cases on hand, Oct. 1 (Statuses 10 to 24)	625,098	370,941	59.3	- 1.5	664,927	376,418	56.6	- 1.3
New since Oct. 1	333,439	200,601	60.2	-10.6	373,310	224,309	60.1	- 0.2
Total available	958,537	571,542	59.6	- 4.9	1,038,232	600,727	57.9	- 0.9
Total processed	369,499	220,433	59.7	- 5.7	413,563	233,842	56.5	1/
Rehabilitated	226,926	129,866	57.2	- 6.2	255,881	138,380	54.1	- 2.9
Not rehabilitated (28)	104,613	67,795	64.8	NA	116,156	NA	NA	NA
Not rehabilitated (30)	37,960	22,772	60.0	NA	41,526	NA	NA	NA
Cases on hand, Sept. 30 (Statuses 10 to 24)	589,038	351,109	59.6	- 4.3	624,669	366,885	58.7	- 1.4

1/ Less than 0.05 percent

NA - Not available

FIGURE E

SEVERELY AND NON-SEVERELY DISABLED PERSONS REHABILITATED, FY 1974 - 1982

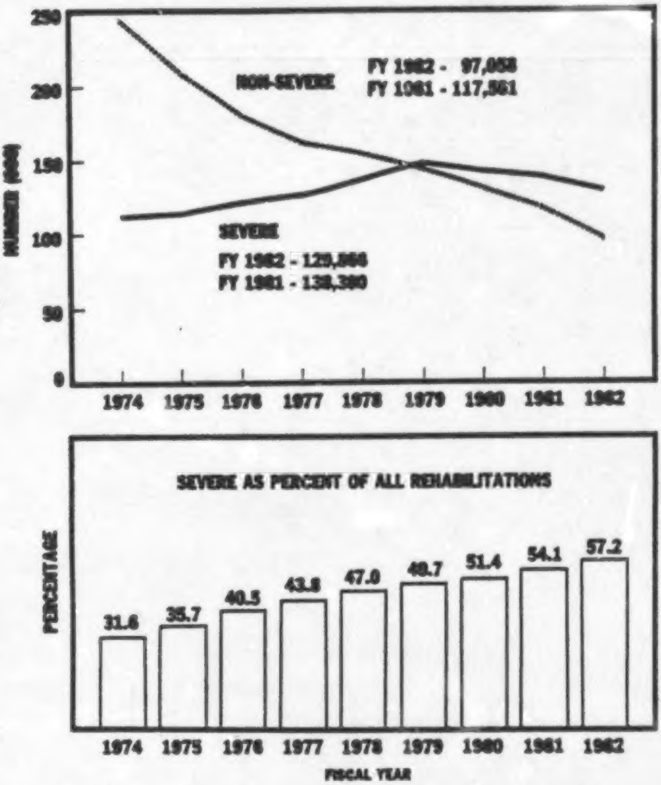


Table 11. — Persons rehabilitated by State vocational rehabilitation agencies and percent change from previous year, by severity of disability: Fiscal Years 1974 - 1982

A. Severely Disabled

Fiscal Year	Rehabilitations	Percent Change 1/
1982	129,866	- 6.2
1981	138,380	- 2.9
1980	142,565	- 0.5
1979	143,373	+ 3.6
1978	138,402	+ 8.5
1977	127,322	+ 3.7
1976	122,938	+ 6.3
1975	115,746	+ 1.5
1974	113,997	2/

B. Non-Severely Disabled

Fiscal Year	Rehabilitations	Percent Change 1/
1982	97,054	-17.4
1981	117,501	-12.7
1980	134,591	- 7.1
1979	144,950	- 7.1
1978	155,994	- 4.7
1977	163,680	- 9.3
1976	180,390	-13.4
1975	208,293	-15.7
1974	247,141	2/

1/ Comparison to same period of previous year.
2/ Data not available.

Table 12. — Total, Severely and Non-Severely Disabled Cases Rehabilitated by State Vocational Rehabilitation Agencies and Percent Severe, Fiscal Years 1974–1982

Fiscal Year	Total	Severely Disabled	Non-Severely Disabled	Percent Severe 1/
1982	226,924	129,866	97,058	57.2
1981	255,881	138,380	117,501	54.1
1980	277,136	142,545	134,591	51.4
1979	288,325	143,375	144,950	49.9
1978	294,396	138,402	155,994	47.0
1977	291,202	127,522	163,680	43.8
1976	303,328	122,938	180,390	40.5
1975	324,039	115,746	208,293	35.7
1974	361,138	113,997	247,141	31.6

Table 13. — Rehabilitation Rate for Severely and Non-Severely Disabled Clients of State Vocational Rehabilitation Agencies, Fiscal Years 1976 - 1982

Fiscal Year	Rehabilitation Rate 2/		
	Total	Severe	Non-Severe
1982	61.4	58.9	65.1
1981	61.9	59.2	65.2
1980	64.5	60.9	68.7
1979	64.9	62.1	67.8
1978	64.8	62.5	67.0
1977	64.1	61.4	66.3
1976	62.9	60.0	65.0

1/ Severe as a percent of severe and non-severe cases.

2/ Rehabilitations ÷ (All active cases closed).

FIGURE F

SEVERELY AND NON-SEVERELY DISABLED PERSONS: NEW ACTIVE CASES, FY 1976 - FY 1982

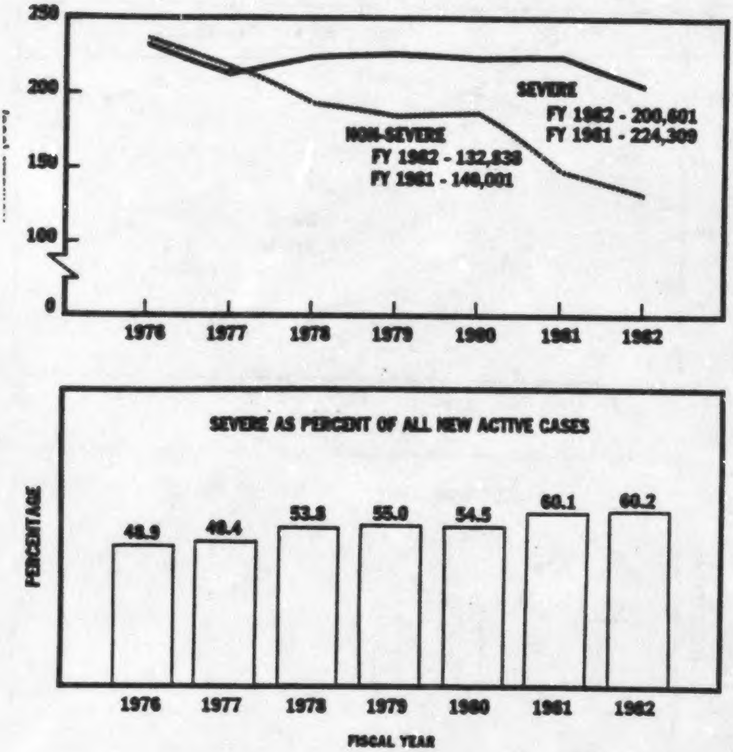


FIGURE G

SEVERELY AND NON-SEVERELY DISABLED PERSONS:
ACTIVE CASES SERVED, FY 1976 - 1982

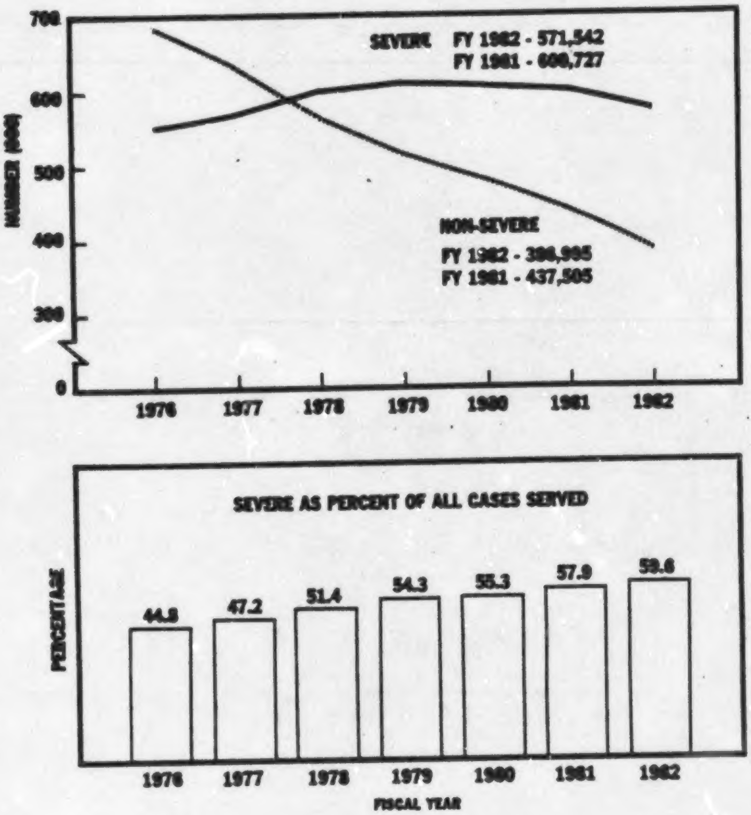


Table 14. — Number of persons severely and non-severely disabled in active caseloads of State vocational rehabilitation agencies and percent severe: Fiscal Years 1976 - 1982

A. New Cases and Cases Not Rehabilitated

Fiscal Year	New Active Cases			Not Rehabilitated (28, 30)		
	Severe	Non-Severe	Percent Severe 1/	Severe	Non-Severe	Percent Severe 1/
1982	200,601	133,353	60.1	90,367	52,008	63.5
1981	224,309	149,001	60.1	95,462	62,220	60.5
1980	224,729	187,627	54.5	91,346	61,326	59.8
1979	226,287	185,273	55.0	87,541	68,717	56.0
1978	225,630	193,960	53.8	83,051	70,795	54.0
1977	214,803	220,341	49.4	79,954	83,752	48.8
1976	224,720	234,900	48.9	82,037	97,102	45.8

B. Cases Served and Cases on Hand at End of Period

Fiscal Year	Active Cases Served			On Hand At End of Period		
	Severe	Non-Severe	Percent Severe 1/	Severe	Non Severe	Percent Severe 1/
1982	571,542	386,993	59.6	351,109	237,924	59.6
1981	600,727	437,305	57.9	366,885	257,784	58.7
1980	606,049	489,090	55.3	372,158	293,173	55.9
1979	611,994	515,557	54.3	381,078	301,890	55.8
1978	600,063	567,928	51.4	378,610	335,139	53.1
1977	568,846	635,661	47.2	361,350	388,229	48.2
1976	555,533	683,078	44.8	350,558	405,386	46.4

1/ Severe as a percent of severe and non-severe cases.

SECTION III

AGENCY TABLES

Table 13 - Number of rehabilitations in State Vocational Rehabilitation agencies: Fiscal Years 1981 and 1982

Region and agency	Total rehabilitations Fiscal year 1982	 1981	Percent change
U. S. Total	226,924	255,881	-11.3
Region I	10,640	11,441	- 7.0
Connecticut	1,872	2,260	-17.2
Maine	966	952	1.5
Massachusetts	4,433	4,394	0.8
New Hampshire	952	961	- 0.9
Rhode Island	1,899	2,117	-10.3
Vermont	546	540	1.1
*Connecticut	122	127	- 3.9
*Massachusetts	411	719	-42.8
*Rhode Island	77	116	-33.6
*Vermont	61	55	10.9
Region II	21,045	21,056	—
New Jersey	5,723	6,413	-10.8
New York	10,229	9,095	12.5
Puerto Rico	3,652	4,209	-13.2
Virgin Islands	39	38	2.6
*New Jersey	348	318	9.4
*New York	1,054	983	7.2
Region III	29,946	38,747	-22.7
Delaware	770	859	-10.4
District of Columbia	1,381	1,487	- 7.1
Maryland	3,637	5,395	-32.6
Pennsylvania	14,421	20,938	-31.1
Virginia	5,087	5,209	- 2.3
West Virginia	3,633	4,073	-10.8
*Delaware	24	31	-22.6
*Pennsylvania	569	267	113.1
*Virginia	404	473	-14.6
Region IV	52,873	58,187	- 9.1
Alabama	5,489	6,606	-16.9
Florida	7,931	8,976	-11.6
Georgia	6,036	7,021	-14.0
Kentucky	3,608	3,557	1.4
Mississippi	4,437	4,589	- 3.3
North Carolina	9,900	9,899	—
South Carolina	8,037	9,169	-12.3
Tennessee	4,793	5,447	-12.0
*Florida	594	681	-12.8
*Kentucky	238	262	- 9.2
*Mississippi	347	354	- 1.3
*North Carolina	646	717	- 9.8
*South Carolina	121	121	—
*Tennessee	214	178	21.1
Region V	38,232	42,226	- 9.5
Illinois	7,051	7,875	-10.5
Indiana	3,232	3,594	-10.1
Michigan	6,705	7,712	-13.1
Minnesota	4,458	4,934	- 9.6
Ohio	9,856	11,246	-12.4
Wisconsin	6,036	6,003	0.5
*Michigan	325	305	6.6
*Minnesota	365	357	2.2

(continued)

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Table 13 - Number of rehabilitations in State Vocational Rehabilitation agencies: Fiscal Years 1981 and 1982

Region and agency	TOTAL REHABILITATIONS Fiscal Year 1982	1981	Percent change
Region VI	32,919	36,354	- 9.4
Arkansas	3,507	3,624 a/	- 3.2
Louisiana	6,043	6,289	- 3.9
New Mexico	1,000	944	5.9
Oklahoma	6,544	7,486	-12.6
Texas	13,900	15,860	-12.3
*Texas	1,925	2,151	-10.5
Region VII	11,256	13,196	-14.7
Iowa	2,187	2,495	-12.3
Kansas	1,246	1,822	-31.6
Missouri	6,173	6,766	- 8.8
Nebraska	1,313	1,686	-22.0
*Iowa	90	109	-17.4
*Missouri	172	232	-25.9
*Nebraska	75	86	-12.8
Region VIII	8,395	9,217	- 8.9
Colorado	2,554	3,034	-15.8
Montana	918	931 b/	- 1.4
North Dakota	756	842	-10.2
South Dakota	772	869	-11.2
Utah	1,641	1,730	- 5.1
Wyoming	747	747	**
*Utah	67	74	- 9.5
Region IX	15,005	17,070	-12.1
American Samoa	13	NA	—
Arizona	1,577	2,049	-23.0
California	11,064	12,742	-13.2
Guam	102	76	34.2
Hawaii	1,041	942	10.5
Nevada	1,030	1,186	-13.2
Northern Marianas	27	17	58.8
Trust Territory	151	58	160.3
Region X	6,388	8,109	-21.3
Alaska	305	338	- 9.8
Idaho	1,040	1,043	- 0.3
Oregon	1,736	2,390	-28.2
Washington	2,944	4,002	-26.4
*Idaho	56	53	5.7
*Oregon	78	142	-45.1
*Washington	209	211	- 0.9

* Agency for the blind

a/ Estimated

b/ Combined data for general and blind agencies

NA Not Available

** - Less than 0.05 percent

Table 1A - Number of severely disabled rehabilitations in State
Vocational Rehabilitation agencies
Fiscal Years 1981 and 1982

Region and agency	Severely disabled rehabilitations Fiscal Year 1982	1981	Percent change	Percent severe
U. S. Total	129,806	138,380	- 6.2	57.2
Region I	7,912	8,158	- 3.0	74.4
Connecticut	1,108	1,337	-17.1	59.2
Maine	749	658	13.8	77.3
Massachusetts	3,684	3,518	4.7	79.5
New Hampshire	637	669	- 4.8	66.9
Rhode Island	649	628	3.3	64.9
Vermont	414	331	25.1	75.8
*Connecticut	122	127	- 3.9	100.0
*Massachusetts	411	719	-42.8	100.0
*Rhode Island	77	116	-33.6	100:0
*Vermont	61	55	10.9	100.0
Region II	13,294	13,473	- 1.3	63.2
New Jersey	3,464	4,241	-18.3	60.6
New York	6,829	6,204	10.1	66.7
Puerto Rico	1,599	1,844	-13.3	43.8
Virgin Islands	35	20	75.0	89.7
*New Jersey	311	181	71.8	89.4
*New York	1,054	983	7.2	100.0
Region III	19,439	23,367	-16.8	65.6
Delaware	442	483	- 8.5	57.4
District of Columbia	503	414	21.5	36.2
Maryland	2,076	2,702	-23.2	57.1
Pennsylvania	11,226	14,189	-20.9	77.8
Virginia	2,670	3,202	-16.6	56.4
West Virginia	1,681	1,740	- 3.4	46.2
*Delaware	24	31	-22.6	100.0
*Pennsylvania	460	209	120.1	80.9
*Virginia	357	397	-10.1	88.4
Region IV	28,043	29,019	- 3.4	53.0
Alabama	3,427	4,009	-14.5	62.4
Florida	4,263	4,893	-12.9	53.8
Georgia	3,009	3,056	- 1.5	49.9
Kentucky	1,951	1,656	17.8	54.1
Mississippi	3,005	2,861	5.0	67.7
North Carolina	4,107	4,011	2.4	41.5
South Carolina	4,268	4,033	5.8	52.1
Tennessee	2,147	2,494	-13.9	44.8
*Florida	427	484	-11.8	71.9
*Kentucky	155	179	-13.4	65.1
*Mississippi	317	343	- 7.6	58.0
*North Carolina	555	632	-12.2	66.4
*South Carolina	218	217	0.5	98.6
*Tennessee	194	151	28.5	89.8
Region V	22,509	23,671	- 4.9	58.9
Illinois	5,620	5,307	5.9	79.7
Indiana	1,745	2,036	-14.3	54.0
Michigan	3,321	3,760	-11.7	49.3
Minnesota	2,446	2,698	- 9.3	54.9
Ohio	5,113	5,892	-13.2	51.9
Wisconsin	3,440	3,196	7.6	57.0
*Michigan	323	305	6.6	100.0
*Minnesota	501	477	5.0	88.0

(continued)

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Table 16 -Number of severely disabled rehabilitations in State Vocational Rehabilitation Agencies: Fiscal Years 1971 and 1972

Region and agency	Severely disabled rehabilitations Fiscal year		Percent change	Percent severe
	1972	1971		
Region VI	15,098	14,896	1.4	43.9
Arkansas	2,280	2,149 a/	6.1	65.0
Louisiana	2,471	2,702	- 8.5	40.5
New Mexico	471	563	-16.3	47.1
Oklahoma	1,519	1,704	-10.9	23.2
Texas	6,806	6,116	11.3	40.9
*Texas	1,551	1,662	- 6.7	80.6
Region VII	5,913	6,436	- 8.1	52.7
Iowa	930	1,136	-18.1	42.5
Kansas	807	910	-11.3	64.8
Missouri	3,016	3,222	- 6.4	48.9
Nebraska	864	797	8.4	65.7
*Iowa	90	109	-17.4	100.0
*Missouri	151	202	-25.2	87.8
*Nebraska	75	81	- 7.4	100.0
Region VIII	4,548	5,062	-10.1	54.2
Colorado	1,638	2,092	-21.7	64.1
Montana	472	463 b/	1.7	51.5
North Dakota	446	451	- 1.1	59.0
South Dakota	334	354	- 5.6	43.3
Utah	1,198	1,209	- 0.9	46.4
Wyoming	393	416	- 5.5	52.6
*Utah	67	74	- 9.5	100.0
Region IX	8,379	8,664	- 3.2	57.2
American Samoa	7	NA	—	53.8
Arizona	1,116	1,080	3.3	70.8
California	6,274	6,678	- 6.0	56.7
Guam	38	22	72.7	53.9
Hawaii	517	429	20.5	40.7
Nevada	403	480	-16.0	47.9
Northern Marianas	19	12	58.3	70.4
Trust Territory	96	67	106.3	63.6
Region X	4,304	5,427	-20.5	65.3
Alaska	267	284	- 6.0	52.9
Idaho	764	732	4.3	73.6
Oregon	1,004	1,316	-23.7	57.2
Washington	1,906	2,466	-22.7	64.8
*Idaho	56	53	5.7	100.0
*Oregon	78	142	-45.1	100.0
*Washington	209	202	3.5	100.0

* Agency for the blind.

a/ Estimated

b/ Combined data for general and blind agencies

NA Not available

Table 17 - Number of persons served by State Vocational Rehabilitation agencies- Fiscal Years 1961 and 1962

Region and agency	Total served Fiscal year 1962	 1961	Percent change
U. S. Total	938,537	1,030,232	- 7.7
Region I	47,920	51,117	- 6.3
Connecticut	8,400	9,115	- 7.8
Maine	3,901	3,962	- 1.5
Massachusetts	27,839	28,938	- 3.8
New Hampshire	3,986	3,974	0.3
Rhode Island	4,549	5,154	-11.7
Vermont	2,651	3,026	-12.4
[a]Connecticut	452	473	- 4.4
[a]Massachusetts	1,521	2,057	-26.0
[a]Rhode Island	364	411	-11.4
[a]Vermont	220	227	- 3.1
Region II	100,361	107,173	- 6.4
New Jersey	22,936	23,460	- 2.2
New York	20,431	[illegible]	[illegible]
Puerto Rico	20,991	22,788	- 7.9
Virgin Islands	212	218	- 2.8
[a]New Jersey	1,652	1,609	2.7
[a]New York	4,098	4,633	-12.0
Region III	122,112	140,370	-13.0
Delaware	2,439	2,393	1.9
District of Columbia	6,009	5,630	6.7
Maryland	17,233	23,363	-26.2
Pennsylvania	50,669	60,503	-18.3
Virginia	20,572	21,234	- 3.1
West Virginia	12,993	13,447	- 3.4
[a]Delaware	105	112	- 6.2
[a]Pennsylvania	3,326	2,846	16.9
[a]Virginia	1,366	1,632	- 5.1
Region IV	210,507	220,365	- 4.5
Alabama	25,291	26,786	- 5.6
Florida	31,582	33,417	- 5.5
Georgia	24,673	25,231	- 2.2
Kentucky	15,091	14,331	5.3
Mississippi	17,0[illegible]5	16,951	0.6
North Carolina	36,273	37,597	- 3.5
South Carolina	32,230	35,034	- 8.0
Tennessee	17,886	20,024	-10.7
[a]Florida	2,479	2,721	- 8.9
[a]Kentucky	857	976	-12.2
[a]Mississippi	1,711	1,675	2.1
[a]North Carolina	3,631	3,788	- 4.1
[a]South Carolina	872	950	- 8.2
[a]Tennessee	896	894	0.2
Region V	169,031	179,775	- 6.0
Illinois	29,747	30,553	- 2.6
Indiana	14,229	15,166	- 6.2
Michigan	32,941	38,738	-15.0
Minnesota	22,004	23,086	- 4.7
Ohio	39,381	42,893	- 8.2
Wisconsin	27,073	25,716	5.3
[a]Michigan	1,673	1,699	- 1.5
[a]Minnesota	1,981	1,924	3.0

(continued)

See footnotes at end of table.

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Table 17 - Number of persons served by State-Vocational Rehabilitation agencies: Fiscal Years 1981 and 1982

Region and agency	Total served		Percent change
	Fiscal Year		
	1982	1981	
Region VI..................	130,280	140,865	- 7.5
Arkansas..............	13,601	13,308 a/	2.2
Louisiana.............	31,306	31,709	- 1.3
New Mexico............	3,677	4,029	- 8.7
Oklahoma..............	29,788	32,602	- 8.6
Texas.................	46,438	52,767	-12.0
*Texas................	5,259	6,110	-13.9
Region VII.................	45,129	48,639	- 7.3
Iowa..................	12,252	12,596	- 2.7
Kansas................	4,893	6,027	-18.8
Missouri..............	20,597	21,193	- 2.8
Nebraska..............	5,452	6,608	-17.5
*Iowa.................	347	360	- 3.7
*Missouri.............	1,031	1,245	-17.2
*Nebraska.............	358	424	-15.6
Region VIII................	34,430	36,582	- 5.9
Colorado..............	10,354	11,593	-10.7
Montana...............	3,911	4,246 b/	- 7.9
North Dakota..........	3,707	4,115	- 9.9
South Dakota..........	3,407	3,492	- 2.4
Utah..................	10,320	10,413	- 0.9
Wyoming...............	2,443	2,413	1.2
*Utah.................	288	310	- 7.1
Region IX..................	68,877	77,170	-10.7
American Samoa........	38	NA	- -
Arizona...............	7,113	7,328	- 2.9
California............	52,862	61,104	-13.5
Guam..................	286	331	-13.6
Hawaii................	5,494	5,391	1.9
Nevada................	2,396	2,433	- 1.5
Northern Marianas.....	64	48	33.3
Trust Territory.......	385	322	19.6
Region X...................	30,910	35,940	-14.0
Alaska................	1,898	2,035	- 6.7
Idaho.................	4,454	4,396	1.3
Oregon................	7,988	8,577	- 6.9
Washington............	14,861	18,932	-21.5
*Idaho................	208	223	- 6.7
*Oregon...............	316	419	-24.6
*Washington...........	984	1,164	-15.5

* Agency for the blind
a/ Estimated
b/ Combined data for general and blind agencies
NA Not available

Table 18 - Number of severely disabled persons served by State vocational rehabilitation agencies: Fiscal Years 1981 and 1982

Region and agency	Severely disabled persons		Percent change	Percent severe
	Fiscal Year			
	1982	1981		
U. S. Total	571,342	600,727	- 4.9	59.6
Region I	35,123	36,383	- 3.7	73.3
Connecticut	4,970	5,649	-12.1	59.1
Maine	3,170	2,818	12.5	60.3
Massachusetts	17,386	17,548	- 0.9	79.0
New Hampshire	2,677	2,743	- 2.4	67.0
Rhode Island	2,501	2,771	- 9.7	50.0
Vermont	1,942	1,907	1.8	73.3
*Connecticut	481	503	- 4.4	100.0
*Massachusetts	1,311	2,007	-35.0	100.0
*Rhode Island	364	411	-11.4	100.0
*Vermont	230	237	- 3.1	100.0
Region II	62,774	68,571	- 8.3	63.3
New Jersey	15,081	17,360	-13.1	65.7
New York	35,913	38,218	- 6.0	60.2
Puerto Rico	9,038	9,889	- 8.6	64.0
Virgin Islands	130	187	-27.8	63.7
*New Jersey	1,382	1,176	17.7	98.9
*New York	6,090	6,835	-11.0	100.0
Region III	80,155	89,900	- 8.8	67.9
Delaware	1,322	1,306	1.2	57.7
District of Columbia	2,646	1,979	33.6	40.7
Maryland	7,264	12,061	-39.6	59.3
Pennsylvania	44,890	56,088	-20.3	79.2
Virginia	12,816	13,770	- 6.9	62.3
West Virginia	6,880	6,974	- 1.3	38.4
*Delaware	105	112	- 6.2	100.0
*Pennsylvania	3,635	3,119	16.7	79.2
*Virginia	1,430	1,463	- 2.3	92.6
Region IV	123,441	127,340	- 3.2	59.7
Alabama	17,210	18,207	- 5.4	66.1
Florida	18,443	19,720	- 6.3	58.3
Georgia	14,480	13,500	7.2	58.7
Kentucky	9,083	8,087	12.3	60.2
Mississippi	12,429	11,916	4.3	73.1
North Carolina	18,104	18,330	- 1.2	49.9
South Carolina	18,791	18,382	2.3	58.3
Tennessee	9,239	10,500	-11.9	55.2
*Florida	1,003	1,143	-12.0	78.0
*Kentucky	396	434	- 8.8	89.3
*Mississippi	1,988	2,048	- 0.1	95.6
*North Carolina	3,394	3,479	- 3.7	71.4
*South Carolina	863	936	- 7.8	99.0
*Tennessee	771	785	- 1.7	87.1
Region V	99,340	102,321	- 2.9	59.0
Illinois	26,083	23,387	10.4	63.0
Indiana	7,376	8,206	-10.1	51.0
Michigan	18,411	21,553	-14.6	53.9
Minnesota	11,636	12,136	- 4.1	53.0
Ohio	19,152	20,740	- 7.2	48.9
Wisconsin	14,342	13,800	4.0	53.7
*Michigan	1,673	1,689	- 1.3	100.0
*Minnesota	1,736	1,827	1.1	98.1

See footnotes at end of table.

(continued)

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Table 18 - Number of severely disabled persons served by State Vocational Rehabilitation agencies: Fiscal Years 1981 and 1982

Region and agency	Severely disabled served		Percent change	Percent severe
	Fiscal Year			
	1982	1981		
Region VI	59,935	63,485	- 5.6	46.0
Arkansas	9,693	8,934 a/	8.5	69.8
Louisiana	10,570	13,879	-23.8	33.9
New Mexico	2,187	2,445	-10.6	39.5
Oklahoma	6,988	7,500	- 6.8	23.5
Texas	26,032	25,650	1.5	56.2
*Texas	2,683	3,077	-11.7	85.2
Region VII	24,298	23,181	4.8	54.1
Iowa	5,206	5,465	- 4.7	42.5
Kansas	3,873	3,149	23.1	79.2
Missouri	9,568	9,676	- 1.1	46.5
Nebraska	4,004	2,974	34.6	73.4
*Iowa	353	368	- 4.0	99.6
*Missouri	842	1,030	-18.3	81.7
*Nebraska	358	419	-14.6	100.0
Region VIII	18,881	20,623	- 8.4	54.8
Colorado	6,899	8,086	-14.7	66.6
Montana	1,835	2,087 b/	-12.1	46.9
North Dakota	2,176	2,398	- 9.3	38.7
South Dakota	1,427	1,451	- 1.7	41.9
Utah	4,908	4,943	- 0.7	47.6
Wyoming	1,348	1,348	**	55.2
*Utah	118	110	+ 7.2	100.0
Region IX	42,287	45,196	- 6.5	61.4
American Samoa	46	NA	- -	45.7
Arizona	4,987	4,154	20.1	70.1
California	32,863	36,828	-10.8	62.1
Guam	152	185	-17.8	53.1
Hawaii	2,541	2,416	5.2	46.3
Nevada	1,355	1,393	-2.7	52.2
Northern Marianas	63	42	50.0	73.0
Trust Territory	290	178	62.9	73.3
Region X	20,855	23,644	-11.8	67.5
Alaska	975	1,022	- 4.6	51.4
Idaho	3,939	3,935	0.1	76.0
Oregon	4,936	5,387	- 8.4	61.8
Washington	9,897	11,933	-17.1	64.6
*Idaho	208	223	- 6.7	100.0
*Oregon	316	419	-24.6	100.0
*Washington	984	1,123	-12.3	100.0

* Agency for the blind.

a/ Estimated

b/ Combined data for general and blind agencies.

NA - Not available
** Less than 0.05 percent.

GLOSSARY OF TERMS

1. Caseload Statuses: There are 14 status classifications under the caseload status coding structure coded in even numbers beginning with 02 and ending with 32 (code 04 is excluded). Following is a brief description of each status:

   a. Status 02 - Applicant: As soon as an individual signs a document requesting VR services, he or she is placed into Status 02 and is designated as an applicant. While in Status 02, sufficient information is developed to make a determination of eligibility (Status 10) or ineligibility (Status 08) for VR services, or a decision is made to place the individual in extended evaluation (Status 06) prior to making this determination.

   b. Status 06 - Extended evaluation: An applicant is placed into this status when a counselor has certified him or her for extended evaluation. Individuals placed into this status may be moved from this status to either Status 10 (accepted for VR) or Status 08 (not accepted for VR) at any time within the 18-month period allowed to complete the eligibility determination.

   c. Status 08 - Closed from applicant or extended evaluation statuses: This status is used to identify all persons not accepted for VR services, whether closed from applicant status (02) or extended evaluation (06).

   d. Active caseload statuses: An individual who has been certified as meeting the basic eligibility requirements is accepted for VR, designated as an active case and placed into Status 10. The active statuses are: Status 10 - Individualized Written Rehabilitation Program (IWRP) development: While in this status, the case study and diagnosis are completed to provide a basis for the formulation of the IWRP. The individual remains in this status until the rehabilitation program is written and approved.

Status 12 - Individualized Written Rehabilitation Program (IWRP) completed: After the IWRP has been written and approved, the client is placed into Status 12 until services have been actually initiated.

Status 14 - Counseling and guidance only: This status is used for those individuals having an approved program which outlines counseling, guidance and placement as the only services required to prepare the client for employment.

Status 16 - Physical or mental restoration: Clients receiving any physical or mental restoration services (e.g. surgery, psychiatric treatment or being fitted with an artificial appliance) are placed into this status until services are completed or terminated.

Status 18 - Training: This status is used to identify persons who are actually receiving academic, business, vocational or personal and vocational adjustment training from any source.

Status 20 - Ready for employment: A client is placed into this status when he or she has completed preparation for employment and is ready to accept a job but has not yet been placed, or has been placed into but has not yet begun employment.

Status 22 - In employment: When an individual has been prepared for, been placed in, and begun employment, he or she is placed into Status 22. The client must be observed in this status for a minimum of 60 days before the case is closed rehabilitated (Status 26).

Status 24 - Service interrupted: A person is recorded in this status if services are interrupted while he or she is in one of the Statuses 14, 16 18, 20 or 22.

e. Active caseload closure statuses: A client remains in the active caseload until completion of the IWRP or case termination. Closures from the active caseload are classified in one of the following three categories:

Status 26 - Rehabilitated: Active cases closed rehabilitated must as a minimum (1) have been declared eligible for services, (2) have received appropriate diagnostic and related services, (3) have had a program for VR services formulated, (4) have completed the program, (5) have been provided counseling, and (6) have been determined to be suitably employed for a minimum of 60 days.

Status 28 - Closed other reasons after IWRP initiated: Cases closed into this category from Statuses 14 through 24 must have met criteria (1), (2) and (3) above, and at least one of the services provided for by the IWRP must have been initiated, but for some reason one or more of criteria (4), (5) and (6) above were not met.

Status 30 - Closed other reasons before IWRP initiated: Closures from the active caseload placed into Status 30 are those cases which although accepted for VR services, did not progress to the point that rehabilitation services were actually initiated under a rehabilitation plan (closures from Statuses 10 and 12.).

f. Status 32 - Post-employment: Persons previously rehabilitated are placed into this status while in receipt of post-employment, follow-up or follow-along services devoted to helping the client maintain employment.

3. Active caseload: The number of cases in the active statuses (10 to 30).

3. Active cases served: The total number of active cases available during the period--the sum of new active cases and active cases on hand at the beginning of the period. It is also the sum of the number of cases closed from the active statuses and the number on hand at the end of the period.

4. Severely disabled: Cases of individuals who fall into any of the four categories listed below: 1. Clients with major disabling conditions such as blindness and deafness, which are automatically included, and other disabilities as qualified, such as a respiratory disorder with sufficient loss of breath capacity, 2. Clients who, at any time in the VR process, had been Social Security Disability Insurance (SSDI) beneficiaries, 3. Clients who, at any time in the VR process, had been recipients of Supplemental Security Income (SSI) payments by reason of blindness or disability, and, 4. Other individual cases with documented evidence of substantial loss in conducting certain specified activities.

5. Severely disabled caseload: The number of cases in the active caseload classified as severely disabled.

6. Rehabilitation rate: The number of cases closed rehabilitated as a percent of all cases closed from the active caseload. (Rehabilitations as a percent of the sum of rehabilitations and non-rehabilitations.)

7. Acceptance rate: The number of cases accepted for VR as a percent of all cases processed for eligibility. (Acceptances as a percent of the sum of acceptances and non-acceptances.)

8. Rehabilitations per 100,000 population: The number of persons whose cases are closed rehabilitated for every 100,000 persons residing in the United States derived from Decennial Census data for 1970 and 1980 and updated for population changes during the interim years and since 1980.

9. Active cases served per 100,000 population: The number of active cases served for every 100,00 persons residing the United States as derived from Decennial Census data for 1970 and 1980 and updated for population changes during the interim years and since 1980.